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ABSTRACT

The first edition of "Child Sexual Abuse: An Interdisciplinary Professional Reference Manual" (ED 279 974) represents a state-of-the-art summary of approaches in child sexual abuse interventions, emphasizing interdisciplinary cooperation between professionals in successful case management. When the first edition was published, survey questionnaires were mailed to purchasers of the manual. As a result of comments received from purchasers, editorial changes and major additions were made in the manual. This document contains new material and revisions of the first edition. To answer a number of comments centered on the fact that there was no general overview of current thinking about the phenomenon of child sexual abuse in modern American society, a brief prologue has been added to provide this overview. Because many respondents requested a section on prevention of child sexual abuse, a section has been added which provides an overview of the major issues and approaches considered crucial in all prevention efforts. In addition to narrative sections of the manual, the service directory of agencies providing services in child sexual abuse intervention and treatment has been updated through July, 1987. These pages are to be used to replace the appropriate pages in the first edition. (NB)

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CG 020725

Child Sexual Abuse

An Interdisciplinary Professional Reference Manual

with
Service Directory
for Central
Massachusetts

The
Worcester Area
Child Sexual Abuse
Task Force

U.S. DEPARTMENT OF EDUCATION
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October 1987
Second Edition

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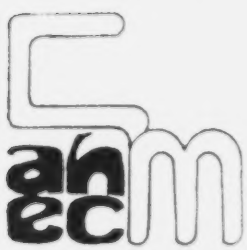

MSPCC

United Way
of Central
Massachusetts

MEMORANDUM

October 9, 1987

TO: Purchasers of **Child Sexual Abuse: An Interdisciplinary Professional Reference Manual**

FROM: The Worcester Area Child Sexual Abuse Task Force

SUBJ: Second Edition

The accompanying pages represent new material and revisions of the first edition of **Child Sexual Abuse: An Interdisciplinary Professional Reference Manual**, published in September, 1986.

For readers who have already purchased a copy of the **Manual**, this packet contains revised and added pages which replace those in the first edition.

For those who are now purchasing the **Manual**, there are two packets in this mailing. One includes the complete first edition. The other, enclosed with this memorandum, represents the second edition revisions to the **Manual**. Please replace the appropriate pages in the first edition with those enclosed in this packet.

The cost of the **Manual** includes these second edition revisions. You will be notified of future revisions and their cost.

The Worcester Area Child Sexual Abuse Task Force wishes again to express our appreciation for your continued interest in the **Manual**. Please feel free to contact us at any time concerning your comments and criticisms.

3. The Worcester Area Child Sexual Abuse Task Force must be compensated in the amount of $2.00 for each copy sold by the reprinting organization or individual. This compensation will be used to amortize original development costs.

4. The Worcester Child Sexual Abuse Task Force maintains a list of all purchasers of the Manual. The principal purpose of such a list is to provide a source of evaluation of the Manual. A mailing to purchasers of the Manual has provided the Task Force with information incorporated into a second edition of the Manual in the summer of 1987. It is expected that reprinters of the Manual will maintain such lists and make them available to the Task Force.

Signed

_____ _____
Name Date

_____
Title

_____
Agency or Organization

_____
Street Address

_____
City State Zip

_____
Telephone

_____ _____
Name Date

Chairperson
Title

Worcester Area Child Sexual Abuse Task Force
Agency or Organization

c/o MSPCC, 286 Lincoln Street
Street Address

Worcester, MA 01605
City State Zip

617/ 753-2967
Telephone

Worcester Area Child Sexual Abuse Task Force

REPRINTING AGREEMENT

CHILD SEXUAL ABUSE: AN INTERDISCIPLINARY PROFESSIONAL REFERENCE MANUAL

The publication **Child Sexual Abuse: An Interdisciplinary Reference Manual** was published with the expectation that it would be disseminated and adapted by organizations, agencies, and individuals who purchased it. Large scale reproduction of the Manual, tailored to local area needs and perspectives, are commended by the Worcester Area Child Sexual Abuse Task Force. It is necessary, however, to secure permission for such reprinting from the Task Force.

The Task Force is indebted to many individuals and organizations for their financial and in-kind support of the costs of generating the Manual. Furthermore, composition of the professional content of the Manual was the result of a complex concensus-building process. It is important, therefore, that neither the sources of original development nor the professional integrity of the Manual be lost or compromised in subsequent reprintings, either by the Task Force itself or by another organization.

This agreement constitutes the terms by which the Worcester Area Child Sexual Abuse Task Force grants authorization to reprint the Manual. Please read the conditions, sign the agreement form below, and return the signed form the the Worcester office of MSPCC. The Task Force Chairperson will sign and promptly return this form which becomes an authorization to reprint.

CONDITIONS FOR REPRINTING

_____ agrees to the following articles when reprinting the publication **Child Sexual Abuse: An Interdisciplinary Professional Reference Manual** which was published by the Worcester Area Child Sexual Abuse Task Force in September, 1986.

1. All reprinted editions must contain the title page (cover 1), the inside cover containing logos of the funding agencies (cover 2), the introduction (pp. 1-2), the Distinguished Key Advisors Committee (p. 3), the Foreword (p. 5 (page number not printed) and p. 6), and the acknowledgements (p. 7). Furthermore, Section One (Interdisciplinary Perspectives, pp. 9-24) and Section Two (Intervention Scenarios pp.25-45) must both be reprinted in their entirety with no editorial changes. Furthermore, if the section on "The Medical Examination" is reprinted, credit must be given to the University of Massachusetts Medical Center. Reprinting organizations are encouraged to develop their own materials for any reprinting, but all additional pages or sections must clearly credit the authoring group.

2. The sales price of the Manual is $10.00. This price was determined by the Worcester Area Child Sexual Abuse Task Force by considering production costs and a percentage of the development costs. Although the price flies in the face of economic theories of relative value, ability of users to pay strongly influenced the pricing decision. To sell the publication at less than production costs would devalue it, as would providing it free. It is expected that reprinters of the Manual will sell it at a price of $10.00.

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Preface to the Second Edition

The first edition of Child Sexual Abuse: An Interdisciplinary Professional Reference Manual was published in September, 1986. This second edition is a product of the development and marketing plan which generated the first edition. The Worcester Area Child Sexual Abuse Task Force had built into that plan a systematic format for gathering comments and criticisms from purchasers of the first edition with an eye toward making the content of the Manual more useable and comprehensive.

Toward that end, survey questionnaires were mailed to all purchasers of the first edition in March and April of 1987. As a result of comments received editorial changes were made in the Manual. Two major additions resulted from the survey reviews. First, a number of comments centered on the fact that there was no general overview of current thinking about the phenomenon of child sexual abuse in modern United States society. A brief **Prologue** has been added to provide this overview.

Secondly, many respondents urged us to add a section on prevention of child sexual abuse. Although a conscious editorial decision had been made at the time of the first edition to exclude prevention because of its complexity and because of the focus of the Manual on interdisciplinary perspectives on intervention and treatment, a section has been added to this second edition which provides an overview of the major issues and approaches which the Task Force considers to be crucial in all prevention efforts. Because prevention underlies most efforts in intervention and treatment of child sexual abuse, we feel that the comprehensiveness of the Manual is improved by the addition.

In addition to narrative sections of the Manual, the Service Directory of agencies providing services in child sexual abuse intervention and treatment has been updated through July, 1987.

The Task Force wishes to thank those who were so giving of their time and talents in the development of the first edition for their assistance in this second edition as well. Our Distinguished Key Advisors Committee continues to provide the counsel and guidance which makes a difference in the the prevention and treatment of child sexual abuse. Data General Corporation has continued its support of this Manual through once again providing printing support of the second edition. We again thank Ray Thomas and David Dimmick for this continued support. We also thank Norman Richardson and the Trustees of the Hoche-Scofield Foundation for defraying the costs of the reader survey as well as editorial and production costs attendant on the development of the second edition.

October, 1987

Prologue

Child sexual abuse is a widespread problem and a complex social and psychological phenomenon. Child sexual abuse is defined as engaging in a sexual act with a child. These acts include exposure, fondling, oral sexual contact, anal sexual contact, and intercourse. It is estimated that in this country one in four girls and one in seven boys are sexually abused in some way before the age of eighteen. Most offenders are men (over 90%), with the remaining 5-10% women. Most frequently the offender is known to the child victim. Victims are children and adolescents of all ages. Sexual abuse occurs with equal frequency in families from all social and economic levels.

There are different views as to why child sexual abuse occurs. Some professionals point to psychological and interpersonal factors, while others look to social and cultural determinants of behavior. Although this overview cannot examine the multiple factors responsible for child sexual abuse, central to an understanding of the problem is the recognition that sexual abuse is fundamentally an abuse of power. Typically the offender is a trusted adult in a position of authority over the child. Frequently the child receives substantial nurturance and attention from the adult. The adult is furthermore frequently in a position of providing for the basic needs and protection of the child. The offender abuses this power when he or she assaults the child.

The great increase in reports of sexual abuse in recent years has led to speculation by some that the problem is growing. While it is possible that the problem is increasing in scope, it seems more likely that for the first time many professionals are both hearing more sensitively what children are saying as well as asking more carefully about what children have actually experienced. As a result, we are finding that more children than we had previously thought are being, or have been, sexually abused. We are discovering that the incentives for the child to keep quiet about sexual abuse are complex and powerful. Powerful because of the dependency of the child on the offending adult, and complex because of the child's conflicting emotions about the abuse.

This abusive environment is necessarily a secretive one. The first step in stopping the abuse is to break the secret. Often children require considerable support in order to be able to tell about the abuse. Commonly they have been directly or indirectly threatened and are therefore fearful. Frequently they have both positive and negative feelings about the offender. While they want the abuse to stop, they may have conflicting feelings about "getting the offender in trouble." Children may also feel that the abuse or the trauma of disclosure are their fault and that they will "be punished." We can help them understand that neither the abuse nor the trauma resulting from disclosure is their fault.

The crisis that follows the disclosure of sexual abuse may lead the child to recant the allegation. This recanting is generally a result of the anxieties aroused by the disclosure and should not be seen as a clear indication that the original statements are untrue.

As our understanding of the causes and dynamics of abusive patterns increases, so does our ability to be helpful to children who have been abused and to protect them from further abuse. Clarity and honesty in assessing its causes and dynamics among all persons affected by child sexual abuse provides us with the greatest chance to lower the likelihood of abuse and to diminish the level of trauma to children already abused.

The Prevention of Child Sexual Abuse

The different views which influence approaches to the prevention, as well as treatment, of child sexual abuse have been alluded to in the Prologue. Psychological and interpersonal approaches focus on family systems, stress-related behaviors, substance abuse, and child development. Social and cultural approaches point to perceptions of the use and abuse of power, violence, and sex roles. Prevention programs, policies, and practices are derived from these views and are developed at three major levels. The first level is raising the consciousness of society as a whole concerning the incidence of child sexual abuse and the toll which it takes on our young people and adults. It is clear now that the trauma frequently affects a child's growth and development and probably bears direct relationship to juvenile delinquency, crime, substance abuse, prostitution, and suicide. The second level consists of providing the education and supports necessary for parents realistically and creatively to prevent child sexual abuse and, where present, to make a contribution to stopping it. The third level is providing education to children to make them less vulnerable to abuse.

Children have a right to safety, both in the home and in their community. Adults have the responsibility to assure them this right. Because most child sexual abuse occurs in the context of the child's extended family, parents should be educated about (1) the signs of abuse, (2) the importance of personal safety education, and (3) the importance of being approachable by the child for help not only in being able to respond when questioned, but in proactively presenting child sexual abuse as an issue for discussion with the child.

Parents can provide a safe environment, but they cannot necessarily prevent the first approach of an abuser to the child. The education of children about sexual abuse centers on self-protection. While current programs vary as to specific approaches taken, most curricula include information about recognizing a dangerous situation, skills in avoiding and thwarting the abuse, and the importance of telling trusted adults. These programs also emphasize to the children that child sexual abuse is not their fault. In order that children may more confidently trust their own feelings, and act on them, programs should work to increase children's sense of self-worth and self-esteem. Programs which are positive and affirming will strengthen children's relationships with trusted adults and relieve the anxiety which many children feel toward some adults.

But the education of the parent and the mastery of responses by children is not enough. Children do not always have available a trusted adult. Furthermore, children are vulnerable in the presence of adults because they lack the knowledge which adults have and are physically, emotionally, and financially dependent on them. Because of this inherently unequal relationship between child and adult, child sexual abuse is never the child's fault.

Teachers, youth leaders, and others who are responsible for the safety of children outside of the home should be educated to recognize this vulnerability. All communities have the responsibility to make prevention programs available to children and adults. A comprehensive approach to preventing child sexual abuse should have programs which are age appropriate and start early, which include procedures for <u>immediate</u> treatment of cases of child sexual abuse that are disclosed during prevention programs, which remove abusers from future contact with children, which develop protocols for the screening of adults who provide care, education, and other activities for children, and, most importantly, which are continuous and not episodic. Such comprehensive prevention activity is aimed at guaranteeing what we all believe: the right of all children to be safe.

If a child discloses to you

Disclosure of sexual abuse is one of the most difficult things for a child to do. Younger children may disclose accidently, not realizing the implications of what they are telling you. Older children tell in a more deliberate fashion, usually just wanting the abuse to stop and not being fully aware of the implications. It is important both to be aware of general reactions (both yours and the child's) and to know what to do.

GENERAL REACTIONS

The child's attitude and feelings: This is a difficult task for children for numerous reasons (fear of what will happen, guilt, embarrassment, etc.). The child is most probably only telling you a small portion of what has happened to them and what more they tell you and/or anyone else will depend to a great extent on your reaction.

Your reaction: Shock, anger, and confusion are all normal reactions to learning that a child you know has been sexually abused. You may have strong feelings about what the child has told you, but it is important not to alarm the child with a strong emotional response. Use fellow colleagues or your supervisor to process your feelings. If for any reason (e.g. you were abused as a child) you find it too difficult to talk to the child, get someone to help you or to do it for you.

1. **Can I believe what the child tells me?**

   Yes. Even though teenagers have a wider knowledge base than do younger children, many studies show that nearly all children of any age tell the truth when they disclose. In fact, the initial disclosure frequently underrepresents the extent of the abuse. Even if a child retracts the story, this generally comes from being fearful of the consequences or from being threatened by the offender. If a child recants, let them know that you understand why this is hard for them, but that you believe what they originally told you. If a child appears confused and doesn't relate events in a way which seems logical, remember also that this is understandable. Reassure the child. Let the child know that he/she did the right thing in telling you.

2. **How important is it to get as much information as possible from the child?**

   Don't pump the child for details. Children may only be ready to discuss some parts of the abuse. Pushing too much may only further frighten and confuse the child. It is not your job to gather all the facts in the case.

3. **What if the child takes the blame for the abuse?**

   Let the child know that it is not his/her fault. The child needs to know that the victim is never to blame in cases of sexual abuse. Although it is important to let the child know that the offender is to blame, be careful not to express negative feelings toward the offender. Remember that 80% of abused children are abused by people they know and that they have ambivalent feelings toward the offender.

4. **What are some major sources of this ambivalence?**

The offender commonly utilizes authority and power (which often mask insecurity and low self-esteem) to involve the child in a sexually abusive relationship. Often the offender will offer the child favors or privileges to induce them to "keep the secret," thus setting up conflict between the child and other persons who are important to them, for example the other parent or siblings. This commonly eliminates sources of safety for the child both prior to and following disclosure.

5. **How can I maintain rapport with the child?**

Use the child's language and do not put words in the child's mouth. You may think you understand what they are saying, but the child's perception may not be the same as yours. Let the child know that you will do your best to support them. Children need to be protected from further assault. Let them know that you will need to tell other people who can help them keep safe.

6. **How do I decide whether or not to report?**

If you are a mandated reporter you *must* file a 51-A report with the Department of Social Services. Such a report must be telephoned to the Department of Social Services area office. You must then file a written report within 48 hours. See page 33 of this Manual for the report form and see page 29 for a listing of telephone numbers to call.

7. **Should I notify the parents of the child of my report?**

The factors to consider are numerous, and it may be important to seek consultation before acting. Some factors are: concern that a parent might disappear with the child if informed, presence of the offender in the home, and current therapy and services provided to family members. The ruling consideration is the safety of the abused child. If you believe that the child will be put in jeopardy as a result of informing the parents, you should not do so. At any rate, notify DSS of your decision, and consult with them concerning difficult issues; they deal with such issues all the time and will be glad to answer your questions.

8. **Should I notify the alleged offender that a 51-A report is being filed?**

The Department may, in the interest of the child's safety, choose to interview the child **before** the offender is notified of the report. In any event, it is not advisable to notify the offender of the report before contacting the Department of Social Services.

9. **If I work in an agency, school, hospital, or other institution, who should I notify that a 51-A report has been filed?**

Most organizations have a policy regarding the individuals who need to be involved or advised of a 51-A report. If yours does not, it would be advisable to develop such policy guidelines. Generally, a "need to know" basis is the best starting point. An extremely important consideration is confidentiality which protects the rights of all concerned as well as the child's safety. Where the alleged offender is an employee or volunteer of the reporting organization, confidentiality is of added importance.

Child Sexual Abuse and the Schools

A school-aged child spends about one third of his or her total time or one half of awake time in school during the school year. Teachers, counselors, school nurses, and administrators, therefore, are in a position to spot the signs and symptoms of child sexual abuse with a clinically objective eye and a perspective that can be uniquely insightful. Many first disclosures occur at school which makes school personnel important in the reporting of sexual abuse cases.

Dealing with a student who has disclosed or who shows signs or indicators of sexual abuse need not be difficult for school personnel. Although the time demands placed on educating many children often interfere with devoting additional time to such matters as reporting abuse, it is essential that suspicions of abuse be addressed when they occur. If they are not, the student's progress in school will be impeded and the ability to perform to capacity threatened.

It is important to understand that all reporters who suspect child sexual abuse and file a 51-A report are protected from civil and criminal action by law. Time is of the essence when abuse is suspected.

The following guidelines are recommended for school personnel:

1. Discuss suspicions with the school guidance counselor, principal, or other designated individual on the day you first suspect abuse. Such a person may be aware of issues that help to clarify your suspicions or observations.

2. The guidance counselor and the person who suspects the abuse (e.g. teacher) need to contact the principal on the same day that suspicion occurs. If the principal is absent, the individual assuming the principal's responsibilities on that day should be contacted.

3. This group then decides whether other professionals (e.g. school nurse or psychologist) should be contacted immediately so as to provide additional information and perspectives. However, if such consultation will lead to delays which will place the child at risk for further abuse, and the suspicion of abuse is based upon strong evidence, the decision whether or not to file should be made without such consultation.

4. The decision whether or not to file a report to the Department of Social Services must be made as soon as possible. If a team approach is used in making this decision, unresolvable differences may inhibit filing as a team. It is important to note, however, that each team member by law is a mandated reporter in his or her own right (see the Amendments to the 51-A law on page 132 of this Manual). Therefore, the designated leader of the team (for example, the principal) needs to take prompt action once the information has been presented by the team.

5. It is beneficial, for the purposes of continuity of care and support, for school personnel (for example the principal or guidance counselor) to be available to the student, his/her parents and/or guardian, as well as the Department of Social Services once a report has been filed.

The post-disclosure period can be difficult for the victim, other students, and siblings. Certain periods require special sensitivity, such as the time surrounding publicity concerning the case, or the time of court proceedings.

These times are also challenging for those staff persons who are working regularly with the victim and his/her family and peers. School personnel should be especially supportive of their colleagues who are most directly affected by their daily contact with such children and their families.

RECORD KEEPING IN THE SCHOOL

1. School personnel may choose to keep their own log of suspected cases with date, notations of injuries or other signs for the purposes of documentation. However, copies of 51-A reports already sent to the Department of Social Services are not required by law to remain in school files. According to Massachusetts student record Regulation 603 CMR 23, records that need to remain in a school file are those records that "reflect the student's educational progress." Therefore, a building head or principal may decide that the 51-A does not meet the "educational progress" criterion and need not keep the 51-A copy on file. If 51-A's are not to remain in the school file, it is recommended that they be destroyed at the school.

2. It may be decided that a copy of the 51-A, the original of which is completed and mailed within 48 hours of the oral report to the Department of Social Services, should be kept in the student's cumulative folder. If the child changes schools during the process of the investigation, the cumulative folder may be sent to the new principal. If the report is substantiated, and if the parent(s) requests removal from the record when released to out-of- state transfer, the principal may decide to call DSS and request an interstate referral to alert school and agency if a reportable condition still exists and the child is suspected to be at risk.

3. During a ten day 51-A investigation, a DSS worker may request reports or information even if a parent objects to their release. Schools are encouraged to develop guidelines and consult legal counsel concerning interpretation of Student Record Law in these matters.

4. Should a case be closed by DSS and school personnel subsequently receive information which suggests that the child has been abused since the original 51-A report was filed, the reporter should reinitiate a 51-A. If action is not forthcoming, the reporter can register a complaint with the District Attorney. *If a new situation of sexual abuse arises involving a child who is already being served by DSS, a new 51-A must be called into DSS.*

5. If a teacher is concerned about anonymity regarding filing, it is important that he or she discuss this with the school's designated agent or team leader, most commonly the principal. According to the Massachusetts child abuse reporting statute (Chapter 119, Section 51-A), the mandated reporter (teacher) notifies the "person in charge of such institution, school, or facility, or that person's agent, whereupon such person in charge or his or her said agent shall then become responsible to make the report in the manner required." The 51-A report, therefore, can be filed in the agent's name only.

Case Management: Human Service and Mental Health Professionals

Human service providers, and many mental health professionals, are accustomed to working through the establishment of networks and cooperative, often multi-disciplinary, relationships among services and organizations. It is often within these networks that disclosures of sexual abuse occur. This raises questions as to which provider should file reports and which provider should follow through with case management.

When a human service provider or mental health professional has reason to believe that a child has been sexually abused, *a 51-A report must be filed*, because all professionals in these fields are identified by law as *mandated reporters*. While it is true that filing such a report can raise difficult treatment and/or case management issues, ensuring the child's safety and protecting the child from further abuse is of paramount importance.

Within the context of an agency or organization, it is often the case that sexual abuse will be disclosed to two or more workers at about the same time; for example, a parent and a child might each disclose an incident of sexual abuse to their individual therapists. Often this situation will raise questions as to which provider should file the 51-A report. All providers should file.

There are also times when several agencies or organizations are involved with a family and may be made aware of the abuse simultaneously. In all such cases, the issue of filing, case management, etc. arises. When several individuals have been made aware of sexual abuse, therefore, it is also often advisable to file a joint report thereby presenting a "united front."

Whatever the decision made, it must be made quickly because the reporting of sexual abuse cannot be delayed for the sake of ensuring that all of the possible clinical implications have been explored at length.

Private practitioners, not working in groups, face a different set of problems. First, knowledge of how and where to file is often incomplete. Questions, which others working in group contexts ask of their colleagues, often go unanswered for the solo practitioner. The Department of Social Services can be consulted directly when questions arise. Page 29 of this Manual contains locations and telephone numbers.

In addition, because private practitioners are more accustomed to dealing with problems by themselves, it is tempting for them to see sexual abuse, (especially in cases where the offender is a family member) solely as a treatment issue which can be resolved with the appropriate therapeutic intervention. Many therapists find the reporting of sexual abuse difficult because it is antithetical to the maintainance of confidentiality between therapist and client. Yet, by law, the Department of Social Services *must* become involved in the management of the case. Some clinicians choose to prepare their clients for such an eventuality by telling them at the outset of therapy that there could be situations involving the safety of the client and/or others, under which strict confidentiality could not be kept.

It is important to note that filing a 51-A does not put the reporter in jeopardy. Massachusetts statute clearly protects mandated reporters. Even in this age of frequent litigation, you are legally protected and will not be held liable for civil or criminal action if you file a 51-A. All you need to ask yourself is: "Do I have reason to believe that neglect or abuse has occurred?"

A common complaint among human service providers is that once the report is filed with the Department of Social Services, there is often inadequate feedback to the reporter about the progress of the investigation. This can become a particularly important concern when the client's interaction with the provider/reporter will be directly affected by the investigation.

The Department of Social Services, however, screens large numbers of reports on a daily basis. It is not always a simple task to communicate with all reporters, or to discriminate between what is privileged information and what is not. The provider has an official responsibility to the client as an advocate and should ensure follow-up of the case and participate in the development of treatment plans. Reporting sexual abuse implies a partnership between the reporter and the investigating agency.

1. **What if two, or more, human service providers are simultaneously aware of suspected abuse?**
   Time is of the essence in filing 51-A reports, and all providers should file. It is also possible to file as a team.

2. **What if a mandated reporter is not sure whether what is observed constitutes sexual abuse?**
   Call DSS and ask their opinion. You can call anonymously, and DSS staff are well trained regarding this issue.

3. **What if you are not contacted by DSS after you file a 51-A?**
   By regulations DSS is required to notify you of their screening decision and the investigation outcome. As a professional, however, you have a responsibility to follow up with DSS regarding the course of your report. Call them.

4. **What if you fear that the child's living situation will become worse if you report?**
   You are a mandated reporter, and you must report. You and DSS should work together to make the best of what might become a bad situation.

5. **Do you inform the parents or caretakers that you will report suspected abuse?**
   If it will not place the child in jeopardy, you usually do. If you are concerned that the parents will increase the abuse after hearing about the report, you may wish to protect the child in the short run by not telling the parents. If you are unsure, first consult DSS and/or other providers of service to the family. In any case, inform DSS of your decision.

Mandated Reporting of Child Sexual Abuse: The 51-A Report

The Massachusetts General Laws, Chapter #119, 51A and 51B, mandate that the Department of Social Services receive reports of child abuse and neglect, including those of sexual abuse, and investigate such reports within ten calendar days. Emergency reports are investigated within 24 hours. All investigations are carried out under the policy of the Commonwealth of Massachusetts which is to "strengthen and encourage family life, so that every family can care for and protect its children." To this end, the Department will make every reasonable effort to serve a family as an intact unit while also intervening to protect the rights of children should the parents not be able to provide the necessary care and protection. This is a difficult balance to achieve, but it is the mandate to the Department in delivering all services.

The Law requires that any mandated reporter, who in his or her professional capacity has reasonable cause to believe that a child under the age of eighteen years is a victim of sexual abuse must immediately report that condition to the Department. The Department defines sexual abuse very broadly. Most reports generally fall within one of the following three categories:

1. Sexual Assault - rape, molestation, fondling, attempted sexual contact, etc.

2. Sexual Exploitation - encouraging a child to engage in prostitution or the obscene or pornographic photographing or filming of a child.

3. Inappropriate exposure of a child to sexual behavior or materials.

In order for the Department of Social Services to take action, the perpetrator of the alleged sexual abuse must be a 'caretaker' to the child. The Department also takes action if the perpetrator is unknown to the reporter. When the Department receives a report where the alleged perpetrator is clearly not a caretaker, the Department takes no action and appropriate referrals are made.

Although interpretations of the meaning of caretaker may vary, the definition generally includes any person entrusted with responsibility for the child in the child's home, a relative's home, a school, or other place where the child frequents. Thus the meaning of 'caretaker' is construed broadly and includes babysitters, school teachers, school bus drivers, and camp counselors.

The Reporting Law contains general provisions which each mandated reporter should know. First, knowledge of child sexual abuse on the part of a mandated reporter can never be considered confidential and privileged communication and thus not reported to the Department. Secondly, the Law provides mandated reporters with statutory immunity from legal liability, either civil or criminal, brought against them for making a report. Third, failure by a mandated reporter to make a required report is punishable by a fine of not more than one thousand dollars. Last, although the Department encourages mandated reporters to inform families at an appropriate time of the need to file and the reasons for filing, the Department itself will not release the reporter's name to anyone. However, anonymity from the family cannot be guaranteed because the Department may be ordered to reveal the reporter's name if there is a subsequent court action.

DSS Protective Intake Policy states:

"The purpose of screening is to determine, based on the facts in the report, whether there is or may be reasonable cause to believe that a child(ren) has been abused or neglected or may be at risk of being abused or neglected by a caretaker. Screening includes consultation with the reporter, Department files (including the Central Registry), and any collateral contacts that may be able to provide corroborative information specific to the reported incident, the child(ren)'s condition, or to assist in determining the initial response. Screening is a key part of the overall process of reporting, identifying, assessing and providing treatment for families and children. It is that part of the process which determines the Department's subsequent actions and intervention with the family."

When making a report to the DSS Protective Screening Unit, you will be asked to give the following information:

1. The name(s), address, present whereabouts, date of birth or estimate of age, and sex of the reported child(ren) and of any other children in the household.

2. The names, addresses, and telephone numbers of the child's parents or other persons responsible for the child's care.

3. The principal language spoken by the child or the child's caretaker.

4. Your name, address, telephone number, profession, and relationship to the child (non-mandated reporters may request anonymity).

5. The full nature and extent of the child's injuries, abuse, or neglect.

6. Any indication of prior injuries, abuse, or neglect.

7. An assessment of the risk of further harm to the child, and if a risk exists, whether it is imminent.

8. The identity of a third party, if any, who gave you any information concerning the case, unless anonymity is requested.

9. The circumstances under which you first became aware of the child's alleged injuries, abuse, or neglect.

10. The action taken, if any, to treat, shelter, or assist the child.

Note that mandated reporters must follow-up a verbal report by a written 51-A report within 48 hours (the 51-A form is reproduced on pages 33 and 34 below).

The purposes of investigation are to determine if there is evidence to believe that a child(ren) has been or may have been abused or neglected or may be at risk of being so by a caretaker, and to protect the child(ren) from further abuse and neglect. Investigation includes: meeting with the parent(s) or parent substitute(s), seeing and interviewing the reported child(ren) and his or her siblings, consultation with collateral contacts,

What Can Happen to Victims

For victims of sexual abuse, finding assistance can be both confusing and frustrating. Nonetheless, the victims of sexual abuse have the right to receive support and services that are respectful of their particular needs and situations. It is important to remember that child sexual assault is never the fault of the victim. This fact should be clearly stated to the child and family. Child sexual assault is traumatic, and there are social service agencies and governmental organizations available to help with the healing process. After sexual abuse has been disclosed, the victim and his or her family may expect the following types of services to be available to them: crisis intervention, counseling (long and short term), advocacy through the legal, medical, and social systems, and protective services.

When child sexual abuse has been disclosed, and the alleged offender is a caretaker or there is no identified offender, a report to the Department of Social Services, known as the 51-A report, should be made. The disclosure may also refer to abuse which happened several years or longer ago; regardless of the length a time which has elapsed, a 51-A report should be filed.

At the time of disclosure there is an evaluation by the social worker of the abuse victim's need for immmediate intervention. Crisis intervention is available to victims regardless of the length of time which has passed since the assault. The need for crisis intervention around a sexual assault may arise immediately after an assault or may recur up to many years afterward. Either could be triggered by many events. A non-exhaustive list includes the disclosure by someone other than the victim, a movie or television program, a realization that someone looks or acts like the offender, or stress unrelated to the assault but which leads the victim to feel that support is needed. This process of overcoming the trauma of sexual assault is stressful for the victim in that many events can trigger extremely painful memories. For this reason support is sometimes needed for years.

A crisis may also occur immediately after a disclosure because of decisions which need to be made regarding counseling, legal issues, and child protection. One purpose of crisis intervention, therefore, is to help the victim and family protect the child from further victimization and to regain the ability to make informed decisions by providing information about resources as well as emotional support.

Other purposes of crisis intervention center on the emotional states and behavior of the victim at the point of disclosure. For many, disclosure is the breaking of a dam that has held back an ocean of conflicting feelings and thoughts. The ensuing turbulence can lead to numbness, depression and suicide, or escapism such as running away. The escapism also can lead to a recanting of the disclosure on the false hope that recanting will make things better. Delaying of disclosure for weeks, months, or years after the abuse is related to such conflicting feelings and escapism, especially when the offender is at once a chief source of emotional and economic support for the abused child.

As the DSS investigation process unfolds, the victim's circumstances are once again reviewed to determine the need for crisis intervention. This review is then used to plan further intervention.

As part of the investigative process, a medical examination is advised for both evidentiary purposes and safeguarding the victim's health. A medical advocate (nurse, rape crisis counselor) can assist the victim by providing information about the examination and may accompany the individual to the examination. If the victim wishes, the advocate can also be present during the examination itself. A medical advocate can let the victim know step-by-step what takes place during the exam. The advocate can assist the victim in asking difficult questions and in helping the victim to remember what questions to ask.

Depending on the risk of violence to the child victim, legal advocacy may be pursued to protect the child. This may result in a court action to remove either the child or the abusive household member from the home. The victim or caretaker may choose to have an advocate's advice and direction throughout the court process. Advocates (DSS Workers, Rape Crisis Counselors, Victim/Witness Advocates, etc.) provide information about the legal system and all steps of the investigative process so that the victim and family can make informed decisions about legal issues. An advocate may serve as escort to the police station, to pre-trial hearings, and to court appearances. Advocates also serve as liaison between the victim and legal personnel by providing information concerning trial dates, names of attorneys, and general orientation to the court process. A legal advocate can also provide emotional support before, during, and after court cases.

Following the DSS investigation, a case is either substantiated or unsubstantiated. If substantiated (and in some exceptional cases when unsubstantiated) all sexual abuse cases are reported to the District Attorney's Office. Service plans are reviewed by the assigned social worker and appropriate referrals are made for each individual to community agencies. In those cases when there has been substantiation, but where prosecution is not an option, and/or the family is unwilling to participate in service, the social worker will try to form a supportive alliance with the family.

Regardless of the outcome of a report of child sexual abuse, the idea of short term or long term counseling should be explored with the family because the investigation alone has been traumatic to those involved. Counselors can help by establishing a relationship with a victim of sexual abuse which will allow the person to express feelings more readily. Victims may experience a wide range of feelings and emotions. A counselor can further assist victims in letting them know that child sexual assault is not their fault. Counselors also assist victims in further developing coping skills and in regaining control over their lives.

Once the case has been reported to the District Attorney's Office, an interdisciplinary team is convened. The team is composed of a representative of the District Attorney's Office, a DSS reprepresentative, and a member of a social service agency. The team discusses treatment and law enforcement issues raised by the case, and the most effective ways to coordinate those efforts.

The case is then sent to the police to be investigated. An investigation is conducted during which the victim is interviewed by a police officer to obtain a statement relating the facts of the incident(s). This investigation may be done separately from a DSS interview. Increasingly more cases are now being jointly interviewed by the police and DSS in the countywide Sexual

Abuse Intervention (SAIN) Teams. If sufficient information is obtained, either a complaint is sought from the Clerk-Magistrate of the local District Court or the case is directly presented to the Worcester County Grand Jury. No complaint is sought, of course, if the police judge the information received to be insufficient.

From here the case enters one of two processes in the trial courts. In the majority of sexual abuse cases (Rape of Child) a three step process ending in the Superior Court occurs. This process begins with a probable cause hearing in the local District Court. The victim is required to testify at this hearing and is also subject to cross-examination by the defense. If the judge is presented with enough evidence to make a finding of probable cause, the case then proceeds to the Grand Jury where the victim again is required to provide testimony. In this instance, however, the defendant and his/her lawyer is not generally present; there is no cross-examination. The Grand Jury then votes either to indict or not to indict the defendant on each particular offense. Lastly, the case proceeds to the Superior Court where the victim, during a trial, may testify and be subject to cross-examination again. It should be noted that there is always the possibility that a defendant offer a plea of guilty at any stage of these proceedings.

The second process that may be followed is retention of jurisdiction of the case in the local District Court. Some cases (Indecent Assault and Battery, for example) are handled by a trial before a judge in the local District Court or a trial in the 6 member jury session of the District Court. In either case, a child victim is again required to provide testimony and be subject to cross-examination (a summary of the court process is given on pages 30-31 of this Manual).

At each phase of either process, the victim and family members can be assisted by a victim advocate from the District Attorney's Victim/Witness Assistance Program. The advocate is available to provide short-term counseling, referral information, and any other assistance. The advocate is also available to assist in the preparation of a victim impact statement. In this statement, a victim or parent can express to the presiding judge their feelings about the effects of the case on them and their thoughts on sentencing. This statement is only made in the event of a guilty finding by a judge or jury, or a guilty plea by the defendant.

Victims may also be eligible for compensation under a Massachusetts program administered by the Department of the Attorney General entitled the Victims of Violent Crimes Compensation Act. The Act recognizes that innocent victims often suffer the effects of a violent crime long after it occurs. In order to receive compensation under the Act, a claim must be filed within one year of the assault unless there is a valid reason for filing later, but in no event more than three years after the assault. Benefits cover reasonable medical, mental health counseling, and ancillary medical expenses. Total benefits may not exceed $25,000. Claims are filed with the clerk of the local district court or the Victim/Witness Assistance Program.

What Can Happen to Offenders

The disclosure of child sexual abuse precipitates a crisis for all those individuals involved, no less so the offender. Typically, the offender responds to the allegations with complete denial. He or she may minimize the allegations, admitting only to 'lesser charges' or that 'no harm was done.' In fewer cases, the offender may admit to being sexually abusive and immediately request help. In any event, it is critical to understand that the disclosure of sexual abuse, in and of itself, will not necessarily result in the offender's stopping the abusive behavior.

Recent studies of known offenders show that more than 90% are male and the remaining 5-10% are female. Although the vast majority of offenders are male, it is important that a child's disclosure of sexual abuse by a female not be discounted, minimized, or ignored.

Similarly, it is most common to hear of an *adult* sexually abusing a child. Many adult offenders, however, report that their first offense was while they were adolescents. Sexual abuse of a child by an older child or an adolescent should not be dismissed as merely 'experimentation,' but dealt with seriously, because the youthful offender is in need of help. In fact, it is recommended that the youthful offender be interviewed with regard to his/her own history because 80% of offenders report having been victims of child sexual abuse themselves. The issues surrounding their earlier childhood victimization are thus heightened by the disclosure of their own assaultive behavior.

The post-disclosure period may be marked by the offender repeating or attempting to repeat the sexual abuse. The offender may threaten or plead with the child, pressuring the child to recant and hoping to reimpose the 'secret.' The offender may also become entrenched in behavior patterns which reflect a false belief that he/she can 'fix' things by being 'good.' It is important to recognize that such behavior is temporary.

Crisis intervention for the offender during this period is critical. The offender often needs to be assessed for such possibilities as a severe depressive reaction, suicidal ideation/attempt, or homocidal threat. With prompt intervention and skillful confrontation, some offenders are able to reverse their initial denial, admit to the charges, and seek treatment.

In evaluating the offender and intervening to protect the child victim, it is important to take note that about half of offenders are later found to have sexually abused multiple children. These children may be siblings of the first victim, friends of the victim, relatives, or children with whom the offender has been in contact elsewhere in the community.

The practice of requiring the offender to cease contact with the child victim immediately upon disclosure is increasingly common. This allows the family more effectively to protect the child from continued abuse, and from the threat of coercion by the offender.

The crisis for the offender may intensify because of the necessity to cope with isolation, family rejection, criminal charges, publicity, and

possible repercussions at the workplace. As mentioned earlier, close monitoring of his ability to manage effectively these stressors is important. The rapidity with which mental health and social service professionals are able to begin to evaluate and treat the offender is frequently affected by the legal and court process.

Most professionals who work with offenders believe that treatment proceeds most effectively if the offender is mandated by the courts to participate in a treatment program and if therapeutic progress is closely monitored by the court. Treatment programs for offenders frequently reflect the belief that, like an alcoholic, the child sexual abuse offender has a lifelong problem which requires a constant measure of control. Self help groups, therefore, such as those offerred through Parents United Chapters, are ongoing and encourage the regular, long-term involvement of offenders.

Case Histories

The following case histories represent fictional cases, and any similarity to a real case is purely coincidental. They are not meant to portray idealized models but represent what the authors feel are "real" cases with all the ambiguity that attempts to describe reality encounter.

Sally A.

Sally is a four year old who lives with her older brother Jimmy and parents, Mr. and Mrs. A. Her day care provider had noticed that for six weeks she had been preoccupied with going to the bathroom and had complained a number of times that her "pee-pee" hurt. The day care provider asked her if anyone had touched her "pee-pee" in a bad or scary way. Initially Sally would not answer, but eventually she stated that "Johnny" had touched her in a way that hurt and scared her. The day care provider didn't know of a "Johnny" in Sally's life, but wondered if perhaps she had meant to say Jimmy, her brother.

When Sally's mother came to pick her up that day, the provider told her what Sally had said. Mrs. A. was surprised and concerned about Sally. She stated that Johnny was a teenager who babysits for many children in the neighborhood. The provider told Mrs. A. that she would notify the Department of Social Services of the allegations.

Following the filing of the 51-A complaint, Mr. and Mrs. A. were contacted by DSS. An appointment was set to interview Sally the following day. During the interview, Sally showed, with the help of anatomically correct dolls, where she had been touched and stated that Johnny, the babysitter, was the offender. The investigator determined that Mr. and Mrs. A. had not been neglectful in allowing Sally to be with Johnny because they had no knowledge of the abuse. The 51-A was substantiated because, although Johnny is not an adult, he was a babysitter and therefore a caretaker. As a result of the report, the parents protected Sally from further abuse and were able to arrange for the help that she needed, which in this case was play therapy.

Johnny B.

Johnny B. is a 13 year old boy who was Sally A.'s babysitter. Following the report that he had sexually abused Sally A., he was interviewed by both DSS and the local police. These interviews established that Johnny had been babysitting for other children whom he may have sexually abused. A further criminal investigation will be held by the police who will, in conjunction with the District Attorney's Office, decide whether there is sufficient evidence to prosecute Johnny.

Johnny is a child himself. Because professionals have found that children's sexually abusive behavior is modeled after behavior which they have observed, it is important to determine where he was exposed to the

behavior which he duplicated in the case of Sally. Johnny lives with his mother and stepfather, Mr. and Mrs. C., and two younger siblings. Johnny told the Department of Social Services investigators that his natural father had been sexually abusing him on weekend visits for the past two years. Future visits were cancelled pending an investigation of the father's home.

There is no indication that Mr. and Mrs. C. are sexual offenders. There is suspicion that Johnny may be sexually abusing his two younger siblings. The Department of Social Services asked Mr. and Mrs. C. to place Johnny in his maternal grandmother's home temporarily. This is to ensure that Johnny is not living with any children whom he could potentially abuse. This is seen as a temporary measure until mental health, social service, and law enforcement personnel can better assess what would be necessary to safeguard other children from Johnny. While treatment for Johnny is important, it is crucial that responsible adults recognize that he is an offender and prohibit him from being alone with children younger than himself. It can be anticipated that substantial cooperation will be needed between this family and the professionals involved if Johnny is to remain a part of the family and also be prevented from abusing younger children.

Kathy D.

Kathy is a 10 year old girl living with her parents. She confided in an adult neighbor that her father had been sexually abusing her for one year. She pleaded with the neighbor not to tell anyone or her father would go to jail. The neighbor decided to honor the child's wishes and not betray her confidence. Kathy began to talk to this neighbor more often about the abuse. Eventually the neighbor realized that the child would not stop being hurt until she, as an adult, informed Kathy's mother of the abuse.

Mrs. D. did not initially believe that Kathy had been abused. But after speaking with Kathy and the neighbor for a few hours, she accepted that it was true. Mrs. D. called the Department of Social Services looking for guidance. She was advised to keep her daughter away from her husband until a social worker arrived.

Mrs. D. met with the social worker before her husband arrived home that day. She acknowledged that her marriage had been a difficult one for many years. With the support of the social worker, she decided that her husband should leave the house in order for her daughter to be safe from further abuse. She obtained a restraining order to ensure that Mr. D. could not re-enter the home. When he arrived home that day, the restraining order was served on him by the police, and he left home.

During the following months, Mrs. D. decided to divorce Mr. D. She was convinced that the abuse was the last straw in a troubled marriage. Meanwhile Kathy had been discussing committing suicide because of the abuse and had been temporarily hospitalized in a psychiatric unit. After hospitalization Kathy continued counseling, and through close collaboration between her counselor and Department of Social Services case managers it was felt that it would be extremely traumatic for Kathy to testify. Her mother had also entered counseling, and both she and Kathy began to face the fact that the abuse had happened and to build a new home for themselves.

The District Attorney also agreed with family therapists that the risks to Kathy at this time were too great for the case to be prosecuted. Mr. D. was not prosecuted and chose not to enter therapy. Nevertheless, Kathy hopes to be able to visit her father. Child protective officials will need to evaluate the frequency and supervision of these visits. The District Attorney's Office will keep this case under pending status for the period of time allowed under law.

Debbie G.

Debbie is a 14 year old girl living with her parents, Mr. and Mrs. G., and three younger siblings. She recently told her guidance counselor that her father had been sexually abusing her for five years. The guidance counselor filed a 51-A report with the Department of Social Services. Debbie stated to DSS that her mother would not believe her and that she did not want to return home. In response to the question concerning whether her siblings had been abused, Debbie said that she did not know. Mrs. G. did not believe Debbie and refused to ask Mr. G. to leave the home. Debbie was placed in foster care pending further assessment of the family.

The other children were interviewed and none of them claimed to have been sexually abused. On the basis of these interviews and the facts of the case, the presiding judge decided to set bail for Mr. G. who returned home despite concerns of some of those involved with the case that he might abuse the other children.

After interviewing Debbie and her father, the District Attorney's Office decided to prosecute Mr. G. Debbie was provided with a Victim/Witness advocate to help her understand and negotiate the court proceedings. She and her mother also entered counseling before the trial.

Mr. G. was convicted of raping his daughter and sentenced to six months in prison. Debbie remains angry at her parents and is not interested in returning to their home. Mr. G. has entered treatment in prison to learn to understand and control his abusive behaviors and hopes to return to the family home following his release. Outpatient therapy will be mandated as part of probation. Mrs. G. has received further counseling and supportive services to help hold herself and her family together while Mr. G. is in prison. She now believes that Mr. G. raped Debbie. Ms. G. is determined to address the family problems and to hold her marriage together. Debbie also continues counseling.

Barbara K.

Barbara is a 15 year old girl who has run away from home twice in the past year. She has been in therapy for six months to address her difficulties at home and in school. She recently told her therapist that her stepfather had been sexually abusing both her and her younger sister for two years. The therapist filed a 51-A report in consultation with the Department of Social Services and also arranged an emergency meeting to tell Barbara's mother, Ms. L. Ms. L. believed the allegations and immediately confronted her husband. Mr. L. admitted that he had been sexually involved with his daughters and agreed to leave home temporarily. Ms. L. obtained a restraining order to ensure that Mr. L. did not return to the home.

The entire family then became involved with social service and mental health professionals. Mr. L. began group therapy with other men who have sexually abused their children. Barbara and her sister meet with individual counselors, as does their mother. This family has decided to try to stay intact, and DSS has agreed that Mr. L. can visit the family every other Saturday morning in the presence of his counselor. He is not to see members of his family at any other time, and all family members have agreed to this condition. This condition remains in effect for six months, at which time the visitation schedule with be reviewed.

Mr. L. was prosecuted by the District Attorney's Office and plead guilty to the offense. Mr. L. received a suspended sentence with an order of probation/treatment from the court.

DEFINITIONS

This Directory presents a listing of all agencies which identified themselves as providers of services in the field of child sexual abuse in their responses to a questionnaire in May, 1986. Inclusion in this directory does not imply endorsement of the agencies and organizations listed here. In addition, because service provision descriptions are based on information taken directly from the questionnaires and despite extensive review for errors and inconsistencies, the Worcester Area Sexual Abuse Task Force does not guarantee that service information is totally complete, or that some programs which were present in May, 1986 are still in existence.

The Directory is organized along two dimensions. The first part is an index of agencies providing services for child sexual abuse arranged by client type and by type of service provided. Client types are: victims, non-offending parents (NOP), offenders, adult survivors of sexual abuse (survivors), and others. The types of service are: crisis intervention, assessment, diagnostic testing, protective services, advocacy, professsionally assisted support and self help groups, prevention and education, individual therapy, and group therapy. The "notes" section also makes mention of couples therapy and/or family therapy when present.

The second part of the Directory is a detailed description of the services provided by each agency or organization. This part is divided into four sub-parts:

(1) Commonwealth of Massachusetts Area Offices
(2) Agencies and Organizations with Special Programs in Child Sexual Abuse
(3) Law Enforcement Agencies and Programs

The following definitions are employed in this Manual:

Crisis Intervention: regular and frequent contact with victims, families, or offenders in the resolution of emergency situations; twenty-four hour hotline is not a requirement of this definition.

Assessment: determination of need for service and type of service; it is not necessary that the determination of need process be formal.

Diagnostic Testing: formal assessment of type and degree of emotional or physical pathology or lack thereof; use of standard instruments and protocols.

Protective Services: actual provision of domiciling or financing for domiciling.

Advocacy: formal representation of client before a court of law, or, formal programs for introducing clients to legal procedures.

Professionally Assisted Support or Self Help Groups: a professional is anyone with an advanced degree in the Human Service or Mental Health Professions; this professional need not be physically present every time the group meets, but a formal reporting procedure between the group and the professional must be involved.

I. Services Provided to Victims

Crisis Intervention & Assessment

Auburn Project
Boston Road Clinic
CAP of Worcester
Decision Institute
DSS
Elmwood Counseling Services
Family Center Project
Family Health & SS Center
Family Service Organization
Friendly House
Grt. Brk. Valley Health Center
Hahnemann Hospital
Head Start
Health Awareness Services
Health Information Referral Service
Herbert Lipton Center
Hubbard Human Services Center
Human Resource Institute
Massachusetts Mentor
Mass. Office for Children
MSPCC
N. Worc. Co. Sex. Abuse Program
N. Worc. Co. Juvenile Probation
Pernet Family Health Agency
Prospect House
Rape Crisis Program
St. Vincent Hospital
Tri-Link
Tri-River Health Center
U. Mass. Medical Center
Valley Adult Counseling Service
Victim/Witness Program
Wells Human Service Center
Worcester Children's Friend Society
Worcester City Hospital
Worcester Youth Guidance Center
Youth Opportunities Upheld

Advocacy

Auburn Project
Boston Road Clinic
CASA Project
DSS
Hahnemann Hospital
Health Information Referral Service
Herbert Lipton Center
Mass. Office for Children
MSPCC
N. Worc. Co. Juvenile Probation
Piedmont Neighb. Opp. Center
Prospect House

Advocacy (cont.)

Rape Crisis Program
Victim/Witness Program
Worcester Co. D.A.'s Office

Diagnostic Testing

Boston Road Clinic
Decision Institute
Family Center Project
Family Health & SS Center
Hahnemann Hospital
Hubbard Human Services Center
Human Resource Institute
Massachusetts Mentor
N. Worc. Co. Sex. Abuse Program
Prospect House
St. Vincent Hospital
U. Mass. Medical Center
Valley Adult Counseling Center
Wells Human Service Center
Worcester Children's Friend Society
Worcester City Hospital
Worcester Youth Guidance Center
Youth Opportunities Upheld

Protective Services

DSS
MSPCC
Youth Opportunities Upheld

Prevention & Education

Auburn Project
Camp Fire
CAP of Greater Worcester
DSS
Family Center Project
Family Counseling Collaborative
Family Health & SS Center
Friendly House
Grt. Brk. Valley Health Center
Head Start
Health Awareness Services
Health Information Referral Service
Herbert Lipton Center
Hubbard Human Services Center
MSPCC
N. Worc. Co. Juvenile Probation
N. Worc. Co. Sex. Abuse Program
Pernet Family Health Agency
Prospect House

I. Services Provided to Victims (continued)

Prevention & Education (cont.)

Rape Crisis Program
Worcester City Hospital
Worc. Co. D.A.'s Office
Worcester Girls Club

Individual Therapy

Auburn Project
Boston Road Clinic
Decision Institute
Elmwood Counseling Services
Family Center Project
Family Counseling Collaborative
Family Health & SS Center
Friendly House
Grt. Brk Valley Health Center
Head Start
Health Information Referral Service
Herbert Lipton Center
Hubbard Human Services Center
Human Resource Institute
Massachusetts Mentor
MSPCC
N. Worc. Co. Sex. Abuse Program
Prospect House
Rape Crisis Program
St. Vincent Hospital
Tri-Link
Valley Adult Counseling Service
Wells Human Service Center
Worcester Children's Friend Society
Worcester City Hospital
Worcester Youth Guidance Center

Group Therapy

Boston Road Clinic
Decision Institute
DSS, Worcester
Family Center Project
Grt. Brk. Valley Health Center
Human Resource Institute
MSPCC
N. Worc. Co. Sex. Abuse Program
Prospect House
Tri-Link
Valley Adult Counseling Service
Worcester Youth Guidance Center

II. Services Provided to Non-Offending Parents

Crisis Intervention & Assessment

Boston Road Clinic
Decision Institute
DSS
Elmwood Counseling Services
Family Center Project
Family Health & SS Center
Grt. Brk. Valley Health Center
Hahnemann Hospital
Health Awareness Services
Health Information Referral Service
Herbert Lipton Center
Hubbard Human Services Center
Human Resource Institute
Mass. Office for Children
MSPCC
N. Worc. Co. Juvenile Probation
N. Worc. Co. Sex. Abuse Program
Pernet Family Health Agency
Prospect House
Psychiatry and the Law Project
Rape Crisis Program
St. Vincent Hospital
Tri-River Health Center
U. Mass. Medical Center
Valley Adult Counseling Service
Victim/Witness Program
Wells Human Service Center
Worcester Children's Friend Society
Worcester City Hospital
Worcester Youth Guidance Center

Advocacy

DSS
Boston Road Clinic
Hahnemann Hospital
Health Information Referral Service
Herbert Lipton Center
Legal Assistance Corporation
Mass. Office for Children
MSPCC
N. Worc. Co. Juvenile Probation
Piedmont Neighb. Opp. Center
Prospect House
Rape Crisis Program
Victim/Witness Program
Worcester Youth Guidance Center

Support & Self Help Groups

Decision Institute
MSPCC
N. Worc. Co. Sex. Abuse Program
Pernet Family Health Agency

Diagnostic Testing

Boston Road Clinic
Decision Institute
Family Center Project
Hahnemann Hospital
Hubbard Human Services Center
Human Resource Institute
N. Worc. Co. Sex. Abuse Program
Psychiatry and the Law Project
St. Vincent Hospital
Valley Adult Counseling Service
Wells Human Service Center
Worcester Youth Guidance Center

Prevention & Education

Camp Fire
CAP of Greater Worcester
DSS
Family Center Project
Family Counseling Collaborative
Grt. Brk. Valley Health Center
Health Awareness Services
Health Information Referral Service
Herbert Lipton Center
N. Worc. Co. Juvenile Probation
N. Worc. Co. Sex. Abuse Program
Pernet Family Health Agency
Prospect House
Rape Crisis Program
Worcester City Hospital

Individual Therapy

Boston Road Clinic
Decision Institute
Elmwood Counseling Services
Family Center Project
Family Counseling Collaborative
Family Health & SS Center
Family Service Organization
Grt. Brk. Valley Health Center
Health Information Referral Service
Herbert Lipton Center
Human Resource Institute
MSPCC
N. Worc. Co. Sex. Abuse Program
Prospect House
Psychiatry and the Law Project
Rape Crisis Program
Valley Adult Counseling Service
Wells Human Service Center
Worcester Children's Friend Society
Worcester City Hospital
Worcester Youth Guidance Center

Group Therapy

Boston Road Clinic
Decision Institute
DSS, Worcester
Family Center Project
Family Counseling Collaborative
Human Resource Institute
MSPCC
N. Worc. Co. Sex. Abuse Program
Prospect House
Psychiatry and the Law Project
Valley Adult Counseling Service

III. Services Provided to Offenders

Crisis Intervention & Assessment

Chandler Street Center
Decision Institute
DSS
Family Center Project
Family Health & SS Center
Grt. Brk. Valley Health Center
Hahnemann Hospital
Herbert Lipton Center
Hubbard Human Services Center
Human Resource Institute
Massachusetts Mentor
Mass. Office for Children
MSPCC
N. Worc. Co. Sex. Abuse Program
Pernet Family Health Agency
Prospect House
Psychiatry & the Law Project
Rape Crisis Program
Tri-Link
Tri-River Health Center
Valley Adult Counseling Service
Worcester Children's Friend Society

Advocacy

DSS
Hahnemann Hospital
Herbert Lipton Center
Piedmont Neighb. Opp. Center
Psychiatry and the Law Project

Diagnostic Testing

Decision Institute
Family Center Project
Family Health & SS Center
Hahnemann Hospital
Hubbard Human Services Center
Human Resource Institute
Massachusetts Mentor

Diagnostic Testing (cont.)

N. Worc. Co. Sex. Abuse Program
Psychiatry and the Law Project
Valley Adult Counseling Service
Worcester Youth Guidance Center

Support and Self Help Groups

Decision Institute
MSPCC
N. Worc. Co. Sex. Abuse Program

Prevention and Education

DSS
Grt. Brk. Valley Health Center
N. Worc. Co. Sex. Abuse Program
Pernet Family Health Agency
Psychiatry and the Law Project

Individual Therapy

Chandler Street Center
Decision Institute
Family Center Project
Family Health & SS Center
Grt. Brk. Valley Health Center
Herbert Lipton Center
Human Resource Institute
Massachusetts Mentor
N. Worc. Co. Sex. Abuse Program
Psychiatry and the Law Project
Tri-Link
Valley Adult Counseling Service
Worcester Children's Friend Society

Group Therapy

Decision Institute
DSS, Worcester
MSPCC
N. Worc. Co. Sex. Abuse Program
Psychiatry and the Law Project
Valley Adult Counseling Service
Worcester Youth Guidance Center

IV. Services Provided to Adult Survivors of Sexual Abuse

Crisis Intervention & Assessment

Boston Road Clinic
Chandler Street Center
Decision Institute
DSS
Elmwood Counseling Services
Family Counseling Collaborative
Family Health & SS Center
Family Service Organization
Grt. Brk. Valley Health Center
Hahnemann Hospital
Health Awareness Services
Health Information Referral Service
Herbert Lipton Center
Hubbard Human Services Center
Human Resource Institute
Mass. Office for Children
MSPCC
N. Worc. Co. Sex. Abuse Program
Pernet Family Health Agency
Prospect House
Psychiatry and the Law Project
Rape Crisis Program
Tri-River Health Center
Valley Adult Counseling Service
Wells Human Service Center
Worcester Children's Friend Society
Worcester City Hospital
Worcester Youth Guidance Center

Advocacy

Boston Road Clinic
DSS
Hahnemann Hospital
Health Information Referral Service
Herbert Lipton Center
MSPCC
Piedmont Neighb. Opp. Center
Prospect House
Rape Crisis Program

Diagnostic Testing

Boston Road Clinic
Family Health & SS Center
Hahnemann Hospital
Hubbard Human Services Center
Human Resource Institute
N. Worc. Co. Sex. Abuse Program
Psychiatry and the Law Project
Valley Adult Counseling Service
Wells Human Service Center

Support and Self Help Groups

Decision Institute
Family Counseling Collaborative
Family Service Organization
MSPCC
N. Worc. Co. Sex. Abuse Program
Rape Crisis Program

Prevention & Education

Decision Institute
DSS
Family Counseling Collaborative
Grt. Brk. Valley Health Center
Health Awareness Services
Health Information Referral Service
Hubbard Human Services Center
N. Worc. Co. Sex. Abuse Program
Pernet Family Health Agency
Prospect House
Rape Crisis Program

Individual Therapy

Boston Road Clinic
Chandler Street Center
Decision Institute
Elmwood Counseling Services
Family Counseling Collaborative
Family Health & SS Center
Family Service Organization
Grt. Brk. Valley Health Center
Health Information Referrral Service
Herbert Lipton Center
Human Resource Institute
N. Worc. Co. Sex. Abuse Program
Prospect House
Psychiatry and the Law Project
Rape Crisis Program
Valley Adult Counseling Service
Wells Human Service Center
Worcester Children's Friend Society
Worcester City Hospital
Worcester Youth Guidance Center

Group Therapy

Boston Road Clinic
Decision Institute
DSS, Worcester
Family Counseling Collaborative
Human Resource Institute
MSPCC
N. Worc. Co. Sex. Abuse Program
Prospect House
Psychiatry and the Law Project
Valley Adult Counseling Service

V. Services Provided to Others

Crisis Intervention & Assessment

Decision Institute
Family Center Project (Siblings, Non-offending fathers)
Family Health & SS Center
Herbert Lipton Center (Families of active cases)
Human Resource Institute
Massachusetts Office for Children
MSPCC (Non-offending fathers)
Pernet Family Health Agency (Family)
Psychiatry and the Law Project (Adolescents)
Rape Crisis Program (Family, Friends)
Valley Adult Counseling Service
Victim/Witness Program (Family)
Wells Human Service Center (Family)
Worcester Children's Friend Society (Family, Caretakers)

Diagnostic Testing

Decision Institute
Human Resource Institute
Psychiatry and the Law Project (Adolescents)
Valley Adult Counseling Service
Wells Human Service Center (Family)

Advocacy

CASA Project (Court-appointed clients)
Herbert Lipton Center
Legal Assistance Corporation
Mass. Office for Children
Piedmont Neighb. Opp. Center
Rape Crisis Program (Family, Friends)
Victim/Witness Program (Family)

Support & Self Help Groups

MSPCC (Parents of victims abused by a non-family member)

Prevention & Education

Camp Fire (Parents)
CAP of Worcester (Parents, teachers, child care providers)
Family Counseling Collaborative (RNs, EMTs, Social Workers, PTA, Teachers' Organizations)
Head Start (Parents)
Herbert Lipton Center (General community, school systems)
MSPCC (Parents, general community, schools, child care professionals)
Pernet Family Health Agency (Family)
Psychiatry and the Law Project
Rape Crisis Program (Community organizations)
Victim/Witness Program (Police, schools, general public)

Individual Therapy

Auburn Project (Non-family members)
Decision Institute
Family Center Project (Siblings, Non-offending fathers)
Family Counseling Collaborative (Siblings)
Herbert Lipton Center (Families of active cases)
MSPCC (Non-offending fathers)
Rape Crisis Program (Family, Friends)
Psychiatry and the Law Project (Adolescents)
Valley Adult Counseling Service
Wells Human Service Center (Family)
Worcester Children's Friend (Family, Caretakers)
Worcester Youth Guidance Center (Siblings, foster parents)

Group Therapy

Decision Institute
Family Counseling Collaborative (Siblings)
Psychiatry and the Law Project (Adolescents)
Valley Adult Counseling Service

Agency Service Descriptions

Commonwealth
of Massachusetts
Regional Offices

Area 10:
Worcester Area Office
340 Main Street, Suite 825
Worcester, Massachusetts 01608
Contact:
Pamela O'Malley
Assistant Area Director
791-1200

For 51-A Contact:
Protective Screening Unit
791-1200

Area 6:
Fitchburg Area Office
435 Main Street
Suite 3100
Fitchburg, Massachusetts 01420
Contact:
David Van Kennen
345-2101

Area 7:
Gardner Area Office
196 Main Street
Gardner, Massachusetts 01440
Contact:
Intake Supervisor
632-9104

Area 8:
Blackstone Valley Area Office
185 Church Street
Whitinsville, Massachusetts 01588
Contact:
Gerald E. Nowosacki
Supervisor, Sexual Abuse Team
234-6213

Area 9:
South Central Area Office
P.O. Box 797
Webster, Massachusetts 01570
Contact:
Intake Supervisor
949-0113

Boston Road Clinic
314 Grafton Street
Shrewsbury, Massachusetts 01420
Contact:
Peter Moran PhD
Clinical Director
845-1172

Service Summary

Crisis Intervention:
Victims, NOP, Survivors
Assessment:
Victims, NOP, Survivors
Diagnostic Testing:
Victims, NOP, Survivors
Advocacy:
Victims, NOP, Survivors
Individual Therapy:
Victims, NOP, Survivors
Group Therapy:
Victims*, NOP, Survivors
* Teens only.

Notes

Twenty-four hour 7 day per week coverage. Play therapy for younger children. Groups of up to ten for teens and adults. Individual couples therapy and couples groups. Family therapy.

Delivery Characteristics

Reimbursable through BC/BS, Medicaid, and commercial carriers. Limited sliding fee scale tailored to individual cases.

Camp Fire - Central Massachusetts Council
100A June Street
Worcester, Massachusetts 01602
Contact:
Katherine Plainte
Executive Director
753-5398

Service Summary

Prevention/Education:
Victims, Other*

* Parents

Notes

Camp Fire's Children's Awareness Training provides information and skill-building opportunities to children in a variety of situations - Camp Fire clubs, church groups, classrooms. Materials are age-appropriate and may be delivered by trained volunteers as well as professional staff.

Delivery Characteristics

Through membership in the Agency. Fees to community organizations and other agencies vary.

CASA Project
340 Main Street, Suite 817
Worcester, Massachusetts 01608
Contact:
Sue Scrogin
Director
757-9877

Service Summary

Advocacy:
Victims

Notes

The Court Appointed Special Advocate for children 0-18 years is involved in care and protection and divorce/custody issues in juvenile and probate family courts. Volunteers, provided through court appointment only, serve as 'lay' guardian *ad litem* to represent the best interests of the child by investigating and reporting to the court and monitoring services to help ensure permanent place of the child in a timely fashion.

Chandler Street Center Program
Spectrum House, Inc.
105 Merrick Street
Worcester, Massachusetts 01609
Contact:
Sybil A. Goldberg
Director of Staff Development and Community Education
799-2753

Service Summary

Crisis Intervention:
Offenders, Survivors
Assessment:
Offenders, Survivors
Individual Therapy:
Offenders, Survivors

Notes

Clients have presenting problems of substance abuse. Services for sexual abuse are incorporated into therapy sessions. When sexual abuse is disclosed, other agencies are involved depending on indications. Couples and family therapy are offered.

Delivery Characteristics

Sliding fee scale. Agency sees clients who are unable to pay.

Child Assault Prevention (CAP) Project of Greater Worcester
Quinsigamond Community College
670 West Boylston Street
Worcester, Massachusetts 01606
Contact:
Donna Russell
Executive Director
853-2300, Ext. 432

Service Summary

Crisis Intervention:
Victims*
Prevention/Education:
Victims*, Other**
* Children pre-school through sixth grade.
** Parents, teachers, child care professionals.

Notes

Four components characterize the prevention education program: (1) Teacher and Staff In-service, (2) Parent Program, (3) Children's Workshop, and (4) Individualized Question/Answer Sessions, which may result in disclosure and initial intervention. Classroom presentations for pre-school through 6th grade, programs for "special needs" children and adolescents, for day care centers, and for neighborhood centers.

Delivery Characteristics

Fees vary, some subsidized programs available.

Decision Institute
340 Main Street, Suite 512
Worcester, Massachusetts 01608
Contact:
Josephine Bottone, MSW
Assistant Director
798-2399 & 798-0321

Service Summary

Crisis Intervention:
Victims, NOP, Offenders, Survivors, Other
Assessment:
Victims, NOP, Offenders, Survivors, Other
Diagnostic Testing:
Victims, NOP, Offenders, Survivors, Other
Self Help Groups:
Victims, NOP, Offenders, Survivors, Other
Individual Therapy:
Victims, NOP, Offenders, Survivors, Other
Group Therapy:
Victims, NOP, Offenders, Survivors, Other

Notes

Family therapists and sexual abuse specialists work in conjunction with clinical psychologists and psychiatrists. One week turnaround on diagnostic tests. Twenty-four hour emergency/crisis line. Family groups and couples groups. Family therapy and couples therapy.

Delivery Characteristics

Sliding fee scale. Reimbursable through BC/BS and commercial carriers.

Elmwood Counseling Services
Worcester Area Community Mental Health Center
70 Elm Street
Worcester, Massachusetts 01609
Contact:
Anita Collins, LICSW
Director
791-6062

Stuart Moskowitz, LCSW
Clinical Director
791-6062

Service Summary

Assessment:
Victims*, NOP, Survivors
Individual Therapy:
Victims*, NOP, Survivors
* Adolescents.

Notes

Couples therapy and family therapy available.

Delivery Characteristics

Sliding fee scale. Reimbursable by BC/BS, Medicare, Medicaid, CMHC, and commercial carriers.

Family Center Project - U. Mass. Medical Center
55 Lake Avenue North
Worcester, Massachusetts 01605
Contact:
Joanne Nicholson, PhD
Co-Director, Family Center Project
856-3163

Mark Horwitz, MSW
Coordinator, Sexual Abuse Treatment Program
856-3163

Service Summary

Crisis Intervention:
Victims, NOP
Assessment:
Victims, NOP, Offenders, Other**
Diagnostic Testing:
Victims, NOP, Offenders
Prevention/Education:
Victims, NOP
Individual Therapy:
Victims, NOP, Offenders, Other**
Group Therapy:
Victims*, NOP

* Group therapy for 7-11 year old girls.
** Assessment and Therapy for siblings and non-offending fathers.

Notes

Crisis intervention as needed both in initial intervention with new families and on-going. Three types of assessment: (1) as part of initial investigation or assessment, (2) long term assessment of parental fitness, (3) assessments to determine treatment needs. Full range of psychological testing and medical team whose members provide therapeutic physical exams to substantiate abuse. Prevention and education on individual basis to individuals in treatment.

Delivery Characteristics

DSS closed referral system. Available only to families on treatment contract except for medical therapeutic physical exams which are open referral.

Family Counseling Collaborative
22 Summer Street
Westborough, Massachusetts 02172
Contact:
Laura Kerzner, MS
Family Therapist
366-4707

Service Summary

Crisis Intervention:
Survivors
Assessment:
Survivors
Self Help Groups:
Survivors
Prevention/Education:
Victims, NOP, Survivors, Other*
Individual Therapy:
Victims, NOP, Survivors, Other**
Group Therapy:
Survivors

* RNs, EMTs, social workers, PTA, teacher's organizations.
** Conjoint sibling therapy.

Notes

Twenty-four hour on call service for adult survivors. Support groups- ongoing open-ended model, 12 week closed model. Family systems approach in individual and couples and family therapy. Group therapy for both male and female adult survivors.

Delivery Characteristics

Sliding scale fees.

Family Health and Social Service Center
875 Main Street
Worcester, Massachusetts 01610
Contact:
Director of Social Work Service
756-3528

Service Summary

Crisis Intervention:
Victims, NOP, Offenders, Survivors, Other
Assessment:
Victims, NOP, Offenders, Survivors, Other
Diagnostic Testing:
Victims*, Offenders, Survivors
Prevention/Education:
Victims**
Individual Therapy:
Victims, NOP, Offenders, Survivors

* Not done for children under 15 years.
** 9-12 years.

Notes

Physicians and social workers commonly perform combined evaluations and assessments. When physicians perform well-child exams they speak to the children about sexual abuse. Individual therapy focuses on play therapy for children 4-12. Few offenders are seen for treatment and large numbers of adult survivors are seen. Therapy for couples or families is available when indicated.

Delivery Characteristics

Sliding fee scale according to family income and number in family. Reimbursable to BC/BS, CMHC, and commercial insurance carriers. Medicaid, AFDC and SSI categories, Jobs Bill Funds.

Family Services of Central Massachusetts, Inc.
31 Harvard Street
Worcester, Massachusetts 01609
Contact:
Jeanne Rosenblatt
Clinical Director
756-4646

Service Summary

Crisis Intervention:
Victims*, Survivors
Assessment:
Victims*, Survivors
Individual Therapy:
Survivors
Group Therapy:
Survivors
* Older Teens. Younger children most commonly referred.

Notes

Adults presenting with acute recall of sexual abuse are seen one or two times a week. They often stay in treatment long term after the initial crisis and are seen weekly. Survivors' therapy groups focus on the sexual trauma. Other therapy groups focus on self-esteem and relationship issues. Couples and family therapy are available conjointly with individual therapy.

Delivery Characteristics

Sliding fee scale. Reimbursable through BC/BS, CMHC, and commercial carriers.

Friendly House Multiservice Center
36 Wall Street
Worcester, Massachusetts 01604
Contact:
William Terrill
Director, Specialized Child Care Unit
755-4362

Service Summary

Crisis Intervention:
Victims*
Assessment:
Victims*
Prevention/Education:
Victims*
Individual Therapy:
Victims*
* 7-14 years.

Notes

The program is recreational in nature, and works closely with schools, other agencies, and families in case management and continuity issues. Assessment with consulting psychologist every 3-6 months.

Delivery Characteristics

Services provided through contract with DSS. No fees.

Great Brook Valley Health Center
32 Great Brook Valley Avenue
Worcester, Massachusetts 01605
Contact:
Joe Cambray, Mental Health Department Head, Victims, NOP
852-1805

P. Caswell
Staff Psychologist, Teens, Offenders
852-1805

J. Kraft, LICSW
Clinical Director, Survivors
852-1805

Service Summary

Crisis Intervention:
Victims*, NOP, Offenders, Survivors
Assessment:
Victims*, NOP, Offenders, Survivors
Prevention/Education:
Victims*, NOP, Offenders, Survivors
Individual Therapy:
Victims*, NOP, Offenders, Survivors
Group Therapy:
Victims*

* Primarily 0-12 years. Staff psychologist works with teens.

Notes

Location facilitates outreach to home and school. Bilingual advocacy capability. Staff psychologist works with teenagers on an as-needed basis.

Delivery Characteristics

Sliding scale of fees. BC/BS and Medicaid reimbursable.

Hahnemann Hospital Social Service
281 Lincoln Street
Worcester, Massachusetts 01605
Contact:
Cindy B. Furhman, MSW, LCSW
792-8145

Service Summary

Crisis Intervention:
Victims, NOP, Offenders, Survivors
Diagnostic Testing:
Victims, NOP, Offenders, Survivors
Advocacy:
Victims, NOP, Offenders, Survivors

Notes

Crisis intervention includes short term counseling and referral. Medical diagnostics only.

Delivery Characteristics

No fees for social service interventions. Reimbursable through BC/BS, Medicaid, and private carriers.

Head Start - Child Development
280 May Street
Worcester, Massachusetts 01602
Contact:
Rosemary Deedy
Supervisor, Social Service
799-3225

Service Summary

Crisis Intervention:
Victims*
Assessment:
Victims*
Prevention/Education:
Victims*, Other**

* 3-4 year-olds.
** Parents

Notes

Child Assault Prevention Program was presented to all Head Start enrollees and parents by trained staff members. Individual therapy provided by agency social workers working with DSS staff.

Delivery Characteristics

Publicly funded program. No fees.

Health Awareness Services of Central Massachusetts, Inc.
71 Elm Street
Worcester, Massachusetts 01609
Contact:
Frances Anthes
Director, ACCESS
756-7123

Service Summary

Crisis Intervention:
Victims, NOP, Survivors
Assessment:
Victims, NOP, Survivors
Prevention/Education:
Victims, NOP, Survivors

Notes

Services are provided through three modes: (1) ACCESS program for pregnant and parenting teenagers and their families, (2) health education programs of the Adolescent Health Care Program, and (3) family planning clinics and adolescent health clinics. Clients receive services through groups and individually.

Delivery Characteristics

No fees for children 12 and under and for teens in ACCESS and Adolescent Health Care Program. Sliding fee scale for family planning services.

Health Information Referral Service
169 Pleasant Street
Marlboro, Massachusetts 01752
Contact:
Bettina Wingate, LCSW
Executive Director
481-8290

Elaine M. Payne, LICSW
Coordinator, Teen Health Center
485-1316

Bonnie Horka
Coordinator, Child Assault Prevention Program
481-8290

Diane Rigney
Coordinator, Rape Hotline
481-8290

Service Summary

Crisis Intervention:
Victims, NOP, Survivors
Assessment:
Victims, NOP, Survivors
Advocacy:
Victims, NOP, Survivors
Prevention/Education:
Victims, NOP, Survivors
Individual Therapy:
Victims, NOP, Survivors

Notes

Rape Hotline, 24 hour. CAP program including parent, teacher, and classroom workshops. Group for rape victims. Family and individual therapy with children and non-offending parent. Services to pregnant and parenting teens, a program for families of victims of violent crimes, a comprehensive teen center, and play therapy.

Delivery Characteristics

Sliding scale fee. Reimbursable through BC/BS and private carriers.

Herbert Lipton Community Mental Health Center
ACCESS Program
45 Pearl Street
Leominster, Massachusetts 01453
Contact:
Carolyn Droser, LICSW
Director
537-6039

Service Summary

Crisis Intervention:
Victims*, NOP*, Offenders*, Survivors*, Other**
Assessment:
Victims, NOP, Offenders, Survivors, Other**
Advocacy:
Victims, NOP, Offenders, Survivors, Other
Prevention/Education:
Victims, NOP, Other***
Individual Therapy:
Victims, NOP, Offenders, Survivors****, Other**

* Provided to active cases.
** Provided to families of active cases, e.g. fathers, sibs, etc.
*** General community, school systems.
**** As part of cases with current sexual abuse of child.

Notes

All families are referred to the ACCESS program by the Department of Social Services. Crisis intervention is provided to referred families. Formal four week family assessment. Some diagnostic testing on a limited basis through the Mental Health Center. Women's and other support groups are run as needed. Special program for training primary prevention to teachers in daycare centers and elementary schools in Worcester County. Group therapy is provided as needed when there are sufficient numbers of client referrals. Couples, siblings, and family therapy provided when appropriate. Couples groups provided for parenting and primary prevention only. ACCESS has a specialized Sexual Abuse Treatment Team composed of ACCESS staff, and clinicians treating cases of sexual abuse in the four outpatient clinics of the center. An ACCESS staff member serves as consultant to the Fitchburg DSS Sexual Abuse Intervention (SAIN) Team.

Delivery Characteristics

Fees are established only for cases in which families have no insurance. Fees of $1-10 are based on client income and are mutually agreed upon by the client and the clinician. No family is refused service because of inability to pay. Reimbursable through BC/BS, Medicaid, and commercial carriers. Due to DSS-DMH funding, the agency does not have limits on the number of client contracts, nor does treatment require adjusting when insurance expires.

Hubbard Human Services Center
Thompson Road
Webster, Massachusetts 01570
Contact:
Michael Gareau, PhD
Clinical Director
943-2600, ext. 272

Service Summary

Crisis Intervention:
Victims, NOP, Offenders, Survivors
Assessment:
Victims
Diagnostic Testing:
Victims, NOP, Offenders, Survivors
Prevention/Education:
Victims
Individual Therapy:
Victims

Notes

Twenty-four hour emergency service psychiatric coverage. Physical and psychosocial assessments. Individual psychotherapy for victims of all ages. Couples and family therapy provided as needed to victims and offenders.

Delivery Characteristics

Sliding fee scale. Reimbursable by most third party payors.

Human Resource Institute
340 Main Street, Suite 512
Worcester, Massachusetts 01608
Contact:
Josephine Bottone
Assistant Director
798-2399 & 798-0321

Service Summary

Crisis Intervention:
Victims, NOP, Offenders, Survivors, Other
Assessment:
Victims, NOP, Offenders, Survivors, Other
Diagnostic Testing:
Victims, NOP, Offenders, Survivors, Other
Individual Therapy:
Victims, NOP, Offenders, Survivors, Other
Group Therapy:
Victims*, NOP, Survivors

* Teens.

Notes

Family therapists and sexual abuse specialists work with clinical psychologist and psychiatrist. One week turnaround on diagnostic tests. Family and couples groups. Family and couples therapy.

Delivery Characteristics

Sliding fee scale. Reimbursable through BC/BS and Medicaid. Clients are not terminated because of expiration of insurance.

Legal Assistance Corporation of Central Massachusetts
332 Main Street, Suite 320
Worcester, Massachusetts 01608
Contact:
Arthur von Keller, IV, Executive Director
752-3718
Toll Free: 1-800-322-0362

Fitchburg Office:
435 Main Street
Fitchburg, Massachusetts 01420
345-0301

Service Summary

Advocacy:

NOP, Other

Notes

The agency represents, in appropriate cases, parents in civil proceedings either to seek custody of the child or to prevent the offending parent from visiting with the child. Agency services are available only to low income individuals. The agency does not represent individuals in any criminal proceedings.

Massachusetts Mentor, Inc.
55 Hudson Street
Northboro, Massachusetts 01532
Contact:
Andrea Schofield, LICSW
Program Director
Specialized Foster Care
393-7711

Christine Steinwand, MA
Program Director
Protective Day Care
393-7711

Michael Klein, LICSW
Divisional Director
Staff Secure Care
393-7711

Service Summary*

Assessment:
Victims, Offenders
Diagnostic Testing:
Victims, Offenders
Individual Therapy:
Victims, Offenders
* Ages up to 18 years.

Notes

The Northboro Division of Mentor offers three services to victims and offenders who are younger than 18 years: (1) long term specialized foster care, (2) protective family day care (youth under seven years only), and (3) intermediate duration staff secure care for offenders. Assessment and diagnostic testing is available for youth of any age within each of the three programs. All three programs offer 24 hour capacity for program clients.

Delivery Characteristics

Outpatient and clinic-based individual and family therapy for families of program clients is available under third party reimbursable referrals (BC/BS and Medicare). Sliding fee scale for diagnostic and assessment services and psychotherapy. All residential services involve referral from DSS, DYS, and DMH. Protective day care (referred through DSS) is available in Marlboro and Framingham only (FY 1987).

Massachusetts Society for the Prevention of Cruelty to Children
286 Lincoln Street
Worcester, Massachusetts 0160
Contact:
Jack Hagenbuch, LICSW
Assistant Regional Director
753-2967 & 1-800-442-3035

Patricia Moran, LICSW
Supervisor, Sexual Abuse Treatment Program
753-2967 & 1-800-442-3035

Patricia Litchfield, M.Ed.
Community Education
753-2967 & 1-800-442-3035

Service Summary

Crisis Intervention:
Victims, NOP, Offenders
Assessment:
Victims, NOP, Offenders**, Survivors**
Advocacy:
Victims, NOP, Survivors
Prevention/Education:
Victims, Others****
Individual Therapy:
Victims%, NOP, Other*
Group Therapy:
Victims%%, NOP, Offenders, Survivors, Others***

* Non-offending fathers.
** For group purposes only.
*** For parents of victims abused by a non-family member.
**** Parent groups, general community, schools, child care professionals.
% 6-18 years.
%% Teens.

Notes

A special sexual abuse treatment team is located in Framingham, and provides some specialized group services for Region II clients who travel there. If MSPCC cannot respond to a crisis within 24-48 hours, the client is referred to an agency that can. Assessment made of client and family. All self-help groups and group therapy programs are part of Parents United. Many prevention programs included an agency produced film "Some Secrets Are For Telling."

Delivery Characteristics

No fees are charged directly to clients. Prevention services for all populations are also covered.

North Worcester County Sexual Abuse Treatment Program
196 Main Street
Gardner, Massachusetts 01440
Contact:
Judy Linkous, Coordinator
632-9104

North Central Human Services
259 Green Street
Gardner, Massachusetts 01440
Contact:
Felicia Hagberg, Coordinator
632-9400

Service Summary

Crisis Intervention:
Victims, NOP, Offenders, Survivors
Assessment:
Victims, NOP, Offenders, Survivors
Diagnostic Testing:
Victims*, NOP, Offenders, Survivors
Self Help Groups:
Victims*, NOP, Offenders, Survivors
Prevention/Education:
Victims, NOP, Offenders, Survivors
Individual Therapy:
Victims*, NOP, Offenders, Survivors
Group Therapy:
Victims, NOP, Offenders, Survivors
* For 6-18 years only.

Notes

The Agency is a chapter of Parents United. Self help groups are twice monthly voluntary meetings of Parents United; participants must be involved in group therapy. Groups include those for non-offending mothers, female victims (separate groups for ages 4-6 (play therapy), 7-12, and 13-18), male victims (ages 11-14), adolescent male perpetrator/victim group (ages 12-16), a male adult perpetrators group (over 17 years), and an adult female survivors group. Prevention/education workshops and consultations to schools and community agencies. Couples and family therapy available as needed. In addition, there is a voluntary group composed of mothers, adolescent victims and perpetrators which is run by the members with professionals as sponsors. Members of the group are being trained for community education, support to other families, and legal advocacy.

Delivery Characteristics

Sliding fee scale. Clients not rejected because of financial status.

Pernet Family Health Agency
237 Millbury Street
Worcester, Massachusetts 01602
Contact:
Elizabeth Reidy, LICSW
Personnel & Program Consultant
755-1228

Service Summary

Crisis Intervention:
Victims, NOP, Offenders, Survivors
Assessment:
Victims, NOP, Offenders, Survivors, Other*
Self Help Groups:
NOP
Prevention/Education:
Victims, NOP, Offenders, Survivors, Other*
* Primarily other family members.

Notes

Nurse and family worker perform crisis intervention and family assessment in the home. Health team reviews assessments to develop treatment plan, advocacy and referral to other agencies. Mothers group and couples facilitation as well as prevention/education activities for mothers, fathers, preschoolers, and adolescents are provided by LICSW.

Delivery Characteristics

Agency programs are funded by contracts with DSS and Health Services are funded by DPH. Group services as well as in home services are included in these contracts and there are no special fees.

Piedmont Neighborhood Opportunity Center, Inc.
41 Piedmont Street
Worcester, Massachusetts 01610
Contact:
Cheri Valentin
Executive Director
754-7274

Service Summary

Advocacy:

Victims, NOP, Offenders, Survivors, Other

Notes

Legal advocacy provided to neighborhood residents.

Delivery Characteristics

Publicly funded. Services provided free.

Prospect House, Inc.
129 Lincoln Street
Worcester, Massachusetts 01605
Contact:
Liz Salmon
Deputy Director, Family & Children's Services: Victims
752-8586, 753-1490, 754-2223

Evelyn Vega
Coordinator, Sharing our Survival: Adults
752-8586, 753-2763

Service Summary

Crisis Intervention:
Victims, NOP, Offenders, Survivors
Assessment:
Victims, NOP, Survivors
Diagnostic Testing:
Victims*
Advocacy:
Victims, NOP, Survivors
Prevention/Education:
Victims, NOP, Survivors
Individual Therapy:
Victims*, NOP, Survivors
Group Therapy:
Victims*, NOP, Survivors

* Teens.

Notes

All services are provided through three age appropriate groups: (1) Prospect House Family Day Care Program, (2) Emergency Adolescent Services Program, and (3) Sharing Our Survival Program. Diagnostic testing is provided to adolescents through the Emergency Adolescent Services. Individual and group therapy provided to clients in Foster Care, Emergency Adolescent Services, and Sharing our Survival.

Delivery Characteristics

Family Day Care sliding scale fee for day care only. No fee for others programs or services. DSS contracts are held in the three programs. No other reimbursement. Open referral on Family Day Care and Sharing our Survival; closed on Foster Care and Emergency Adolescent Services.

Psychiatry and the Law Project
Worcester Area Community Mental Health Center
72 Jacques Avenue
Worcester, Masssachusetts 01609
Contact:
Carlton Watson, LICSW
Director
756-4354

Service Summary

Assessment:
NOP, Offenders, Survivors, Other*
Diagnostic Testing:
NOP, Offenders, Survivors, Other*
Prevention/Education:
Offenders
Individual Therapy:
NOP, Offenders, Survivors, Other*
Group Therapy:
NOP, Offenders, Survivors, Other*
* 15-21 year olds.

Notes

Interventions stress multi-technique assessments and therapies. Treatment may be extended to include family and significant others.

Delivery Characteristics

Sliding fee scale. Reimbursable through BC/BS and Medicaid.

Rape Crisis Program of Worcester, Inc.
1016 Main Street
Worcester, Massachusetts 01603
Contact:
Marianne Winters
Assoc. Director for Direct Service
791-9546

HOTLINE: 799-5700

Service Summary

Crisis Intervention:
Victims*, NOP, Offenders, Survivors, Other**
Assessment:
Victims*, NOP, Survivors, Other**
Advocacy:
Victims, NOP, Survivors, Other**
Self Help Groups:
Survivors
Prevention/Education:
Victims*, NOP, Survivors, Other***
Individual Therapy:
Victims, NOP, Survivors, Other**

* Teens, 14-18 years.
** Other Family Members and Friends.
*** Community Groups.

Notes

Twenty-four hour hotline available. Assessment to determine appropriate referrals. Escort individuals and families to hospitals, police, or courts and describe systems to them. Self help groups and therapy groups as staff time permits. All services are bilingual (Spanish and English) and multicultural.

Delivery Characteristics

All services are provided free of charge.

Saint Vincent Hospital
25 Winthrop Street
Worcester, Massachusetts 01604
Contact:
Sean Palfrey, MD
Chief of Pediatrics
798-6241

Deborah Lebeaux, MSW
Pediatric Social Service
798-6101

Service Summary

Crisis Intervention:
Victims, NOP
Assessment:
Victims, NOP
Diagnostic Testing:
Victims
Individual Therapy:
NOP

Notes

Social service intervention is available at the service site in the hospital (emergency room, outpatient clinic, inpatient services) for patients who have been abused. Crisis intervention consists of support for the victim and family, decisionmaking and planning, and information and referral. Social Service also provides advocacy services in acting as family support and liaison between community agencies and the family until those agencies take over primary care. The medical staff performs physical assessments and therapy. Social Service interviews the child to provide assessment in terms of the emotional trauma experienced by the child. Such assessment is available through the Outpatient Pediatric Clinic. Diagnostic testing is available through the Pediatric Neurodevelopmental Clinic.

Delivery Characteristics

Sliding fee scale for outpatient visits. No special fees. BC/BS and Medicaid reimbursable.

Tri-Link, Inc.
51 Everett Street
Southbridge, Massachusetts 01550
Contact:
Karl Gustafson, LICSW
Coordinator of Clinical Services
765-9101

Service Summary

Crisis Intervention:
Victims*
Assessment:
Offenders**
Individual Therapy:
Victims*, Offenders**
Group Therapy:
Victims*

* Teenagers only.
**Court mandated adolescents only.

Notes

Tri-Link offers juvenile sex offender assessments as well as offender treatment to clients who have completed an assessment and who have their treatment mandated by the court system. Tri-Link only accepts clients whose assessment recommendation is for outpatient treatment. The agency has recently run a closed group for adolescent victims of sexual abuse. In the future this group may be run again. A juvenile sex offenders group may also be run.

Delivery Characteristics

Payment for assessments and treatment are based on a sliding fee scale for those clients from supporting towns. Some insurance carriers accepted.

Tri-River Health Center
East Hartford Avenue
Uxbridge, Massachusetts 01569
Contact:
David Tapscott, MD
Child Victims
278-5573

Charles Sweet, MD
Adults
278-5573

Service Summary

Crisis Intervention:
Victims, NOP, Offenders, Survivors
Assessment:
Victims, NOP, Offenders, Survivors

Notes

Medical facility. Individual crisis counseling by MD. Referral for long term counseling.

Delivery Characteristics

Sliding fees. Reimbursable through BC/BS and Medicaid.

University of Massachusetts Medical Center
Department of Pediatrics
55 Lake Avenue North
Worcester, Massachusetts 01605
Contact:
Pediatric Clinic
856-2853

Emergency Room
856-3511

Service Summary

Crisis Intervention:
Victims, NOP
Assessment:
Victims
Diagnostic Testing:
Victims

Notes

All three types of service take place in the context of a pediatric examination with support from a social worker. Services take place in the Emergency Room (recommended for assault less than 72 hours prior to the examination) or, on a limited basis, in the Sexual Abuse Clinic or Adolescent Clinic, both staffed by multidisciplinary, bilingual teams. Physical examinations and cultures for STD.

Delivery Characteristics

Reimbursable through BC/BS, Medicaid, CMHC, and other private carriers. Services not denied due to inability to pay.

Valley Adult Counseling Service, Inc.
115 Water Street
Milford, Massachusetts 01757
Contact:
Ira Schor, LICSW
Director of Outpatient Services
478-0820 & 839-6921

Steven I. Lessin, PhD
Director of Clinical Services
478-0820 & 839-6921

Bellingham Clinic: 966-1100; 883-1308

Service Summary

Crisis Intervention:
Victims*, NOP, Offenders, Survivors, Other**
Assessment:
Victims*, NOP, Offenders, Survivors, Other**
Diagnostic Testing:
Victims*, NOP, Offenders, Survivors, Other**
Individual Therapy:
Victims*, NOP, Offenders, Survivors, Other**
Group Therapy:
Victims*, NOP, Offenders, Survivors***, Other**

* 18 years.
** Any person 18 years or older.
*** Survivors group under development for Fall 1986.

Notes

Crisis intervention 24 hours a day, seven days a week through out-patient services and a crisis team. Intellectual, achievement, and personality testing. Individual psychotherapy and group therapy of 4-8 clients. Couples therapy and family therapy. Community Support Program offers a variety of day-long programming.

Delivery Characteristics

Sliding fee scale. Reimbursable through BC/BS, Medicaid, and commercial carriers. Services not denied due to inability to pay.

Victim/Witness Assistance Program
Worcester County District Attorney's Office
332 Main Street
Worcester, Massachusetts 01608
Contact:
Anthony J. Pellegrini
Program Director
757-2786

Service Summary

Crisis Intervention:
Victims, NOP, Other*
Advocacy:
Victims, NOP, Other*
Prevention/Education:
Other**

* Any other family member.
** Police, school and the general public.

Notes

The agency provides support and information to victims, their parents, and other family members from initial disclosure/arrest throughout the entire criminal justice process. Contact by clients is often made immediately after disclosure or arrest. Most commonly covered prevention topics are the dynamics of child sexual abuse, the D.A.s reporting bill, and the rights of sexual abuse victims.

Delivery Characteristics

There are no fees for services.

Wells Human Service Center
29 Pine Street
Southbridge, Massachusetts 01550
Contact:
H. Hagelauer, PhD
Executive Director
765-9167

For Crisis Intervention:
Shirley Faucher, MSN
Coordinator, Harrington Memorial Hospital ER Dept.
765-9771

Service Summary

Crisis Intervention:
Victims*, NOP*, Other*
Assessment:
Victims, NOP, Survivors, Other**
Diagnostic Testing:
Victims, NOP, Survivors, Other**
Individual Therapy:
Victims, NOP, Survivors, Other**

* Crisis intervention in performed through Psychiatric Emergency Services at Harrington Memorial Hospital.
** Other family members.

Notes

Family therapy is provided when indicated.

Delivery Characteristics

Sliding fee scale. Reimbursable through most third party payors.

Worcester Children's Friend Society
21 Cedar Street
Worcester Massachusetts 01609
Contact:
Intake Worker
753-5425

Service Summary

Assessment:
Victims, NOP*, Offenders*, Survivors*, Other*
Diagnostic Testing:
Victims
Individual Therapy:
Victims, NOP*, Offenders*, Survivors*, Other*

* Services offered to parents, other adult caretakers, and other family members in the context of provision of services to the referred child.

Notes

Worcester Children's Friend Society is an accredited volunteer multiservice child welfare agency and a licensed, free-standing mental health clinic. An intake worker conducts initial interviews with child and family and then meets with the assessment team to formulate diagnostic plan. Diagnostic testing includes intellectual evaluations and projective/ personality testing. A specialist in therapeutic education performs psychoeducational testing when the client is having school problems. Couples and family therapy is offered when diagnostically indicated.

Delivery Characteristics

Reimbursable through BC/BS, Medicaid, CMHC, and other private carriers. When third party payment expires, a fee is set in consultation with the client based on ability to pay. Sliding fee scale for those without insurance.

Worcester City Hospital
26 Queen Street
Worcester, Massachusetts 01610
Contact:
Cheryl Piccirelli, LSW
Pediatric Social Worker
799-8381/799-8000

Robert W. Sorrenti, MD
Chief of Pediatrics
799-8381

Service Summary

Crisis Intervention:
Victims, NOP, Survivors*
Assessment:
Victims, NOP, Survivors*
Diagnostic Testing:
Victims**
Prevention/Education:
Victims, NOP
Individual Therapy:
Victims***, NOP***, Survivors***

* Occasionally.
** Medical diagnostic testing only.
*** Limited and short term.

Notes

Sexual Abuse Team which encounters many first disclosures. When indicated sheltering is provided in Pediatric Unit. Pediatric social worker provides service integration and advocacy services and performs psycho-social assessments which complement medical assessment. Prevention/education activities in conjunction with MSPCC. Some short term individual therapy through Pediatric Clinic/Adolescent Clinic.

Delivery Characteristics

The Agency accepts all third party payors. No patient is denied service because of inability to pay.

Worcester Girls Club
125 Providence Street
Worcester, Massachusetts 01604
Contact:
Stacy Barr
Assistant House Director
755-9525

Service Summary

Prevention/Education:
Victims*

* Seventy-nine percent of the membership is under age 12.

Notes

The Agency is a membership organization drawing from the public, parochial, and private schools in and around Worcester. Opportunities for participatory recreation and skill development are provided in activities at Lincoln House, Winthrop House, and Camp Kinneywood. The Agency has a program entitled "Kid Ability" which is a national Girls Clubs of America program. Three components of the program are information for parents and educators, training for adult program volunteers, and training for children, ages 6-12.

Delivery Characteristics

Through membership in the agency and/or payment of camp fees.

Worcester Youth Guidance Center
275 Belmont Street
Worcester, Massachusetts 01604
Contact:
Susan V. Quinby
Coordinator, Sexual Abuse Treatment Team
791-3261

Service Summary

Crisis Intervention:
Victims, NOP, Survivors
Assessment:
Victims, NOP
Diagnostic Testing:
Victims, NOP*, Offenders*
Individual Therapy:
Victims, NOP, Survivors, Other**
Group Therapy:
Victims***, Offenders****

* Closed referral.
** Siblings, foster parents.
*** 6-18 year olds.
**** Under 18 years only.

Notes

Phone availabilty (no direct service) 24 hours a day. Couples therapy and family therapy available if there is a child victim.

Delivery Characteristics

Sliding scale with no one denied services because of inability to pay. Reimbursable through BC/BS, Medicaid, and commercial carriers.

Youth Opportunities Upheld, Inc.
"The Village"
979 Millbury Street
Worcester, Massachusetts 01607
Contact:
Paul F. Kelleher, LICSW
Director, Emergency Shelter Programs
757-5579

Service Summary

Crisis Intervention:
Victims*
Assessment:
Victims*
Diagnostic Testing:
Victims*
* Teenagers.

Notes

Emergency shelter for all teens in need of service available 24 hours a day, 7 days a week. Twenty-four hour phone line and supervision for one to one crisis intervention counseling. Initial assessment interview, case conferencing and history taking with families. Individual and group counseling and enrollment in the in-house school. Length of stay averages from 1 to 30 days.

Worcester County District Attorney's Office
Child Abuse Unit
332 Main Street, Fourth Floor
Worcester, Massachusetts 01608
Contact:
Michael E. Donnelly
Assistant District Attorney
Child Abuse Unit Director
755-2786 or 755-8601

Service Summary

Advocacy:
Victims
Prevention/Education:
Victims

Notes

In cooperation with with Areas I, II, IV, or the Department of Social Services, which are all or in part within agency jurisdiction, the agency works to coordinate child abuse investigations. In cooperation with DSS, the Crime Prevention and Control Unit of the Massachusetts State Police, and other police departments the office participates in the operation of three special interdisciplinary videotaping teams geared to quick response to abused children. Also work with local schools, police departments, and human services agencies in providing information on child abuse and the laws concerning its reporting and prosecution.

Delivery Characteristics

There are no fees for services.

SKELETAL EXAMINATION

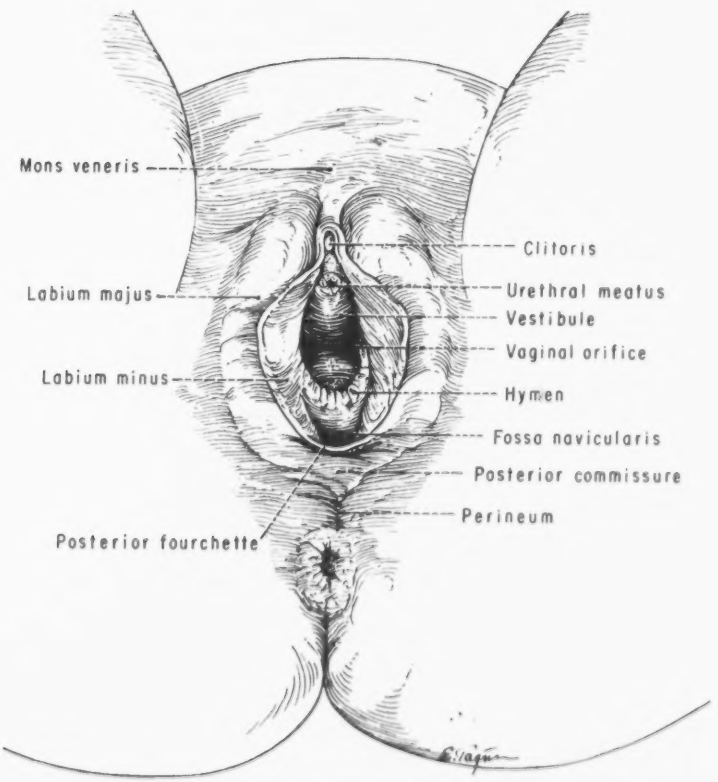
The child should be examined for evidence of acute or healing bony lesions. In cases of reasonable suspicion of trauma, a skeletal survey should be obtained. For any area of the body showing evidence of specific bony injury, plain films of that area should be obtained in addition to the skeletal survey.

GENITAL AND RECTAL EXAMINATION

The child should be psychologically prepared prior to this part of the examination. That is, they should be told what will be done and how it will be done at a verbal skill-level consistent with the child's development. This important communication can be supplemented with the use of anatomically correct dolls. All children with alleged or suspected sexual abuse or assault require a careful and complete inspection of the external genitalia and rectum. Partial exams are never indicated, despite the localized nature of contact revealed by the history.

For females, an internal examination is required for:

1. Symptoms referrable to pelvic organs (abdominal pains, vaginal discharge, dysuria, etc.).
2. Findings on external examination that may indicate penetration.
3. Any question regarding the nature or extent of the assault.



SOME HYMEN VARIATIONS

The examination may be modified according to the age of the child. The following list gives common variations.

1. Position for Inspection:
   - Under Seven Years: Knee-chest position in mother's lap/exam table or Lithotomy.
   - Seven-Twelve Years: Knee-chest or Lithotomy.
   - Over Twelve Years: Lithotomy.

2. Visualization:
   - Under Seven years: Otoscope head.
   - Seven-Twelve Years: Otoscope head or specula (Hoffman or baby H.).
   - Over Twelve Years: Speculum (Hoffman or Pederson).

3. Specimen Collection:
   - Under Seven Years: N-P Swab or Clinitest Dropper.
   - Seven-Twelve Years: N-P Swab or Dropper.
   - Over Twelve Years: Q-Tip or N-P Swab.

4. Palpation:
   - Under Seven Years: Recto-abdominal, Bimanual.
   - Seven-Twelve Years: Recto-abdominal or 1 Finger Vaginal-Abdominal.
   - Over Twelve Years: 1-2 Finger Vaginal-Abdominal.

For females, describe any bruises, abrasions, lacerations, condyloma, discharge, dried secretions, edema, or erythema of the vulva or hymen. Describe any fissures, scars, or adhesions within the vagina. Describe the condition of the hymenal ring and measure the diameter of the hymenal opening.

For males, careful inspection of the penis, scrotum, and rectum should be performed. Describe any lesions, discharge, edema, blood, erythema, or lacerations and note the rectal tone.

In summary, physical findings suggestive of sexual abuse include:

1. Genital or rectal trauma (signs may include bruises and bleeding of the genitals or perianal area, erythema indicating increased vascularity behind the posterior forchette, small healed transections of the hymen, thickening and/or hyperpigmentation of the labial skin, or any abrasions, lacerations, or edema);
2. Foreign bodies in the vagina, rectum, urethra, or penis;
3. Dilation of the vaginal opening, urethra, or rectum;
4. Evidence of semen or acid phosphatase on the child's body or in the urine of females;
5. Trauma to the breast, buttocks, thighs, or lower abdomen;
6. Evidence of sexually transmitted diseases, including gonorrhea, syphilis, genital herpes, trichomonas, chlamydia (beyond 6 months of age), lymphogranuloma venerum;
7. Vaginitis - nonspecific or candidiasis;
8. Recurrent urinary tract infections;
9. Pregnancy.